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Occupational therapy discharge planning and recommendations in acute care: An action research study

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OCCUPATIONAL THERAPY DISCHARGE PLANNING AND
RECOMMENDATIONS IN ACUTE CARE: AN ACTION RESEARCH STUDY

by

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Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in Occupational Therapy

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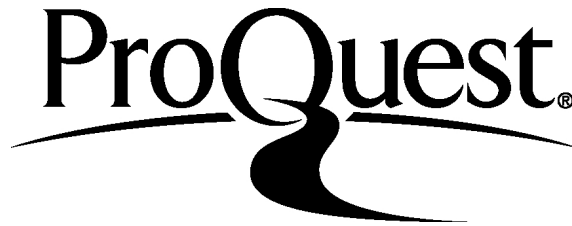
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Abstract

In today's health care environment of quick discharges and shortened hospital stays discharge planning has become increasingly important in acute care occupational therapy practice. Discharge planning is a complex process and an important aspect of patient care as poor discharge planning has been associated with poor patient outcomes and increased risk of adverse events and readmission. This study addressed the following research questions: (a) How do acute care occupational therapists describe their role in the discharge planning process? (b) What guides acute care occupational therapists discharge decisions and recommendations? (c) How do acute care occupational therapists define optimal discharge planning? and (d) What actions can acute care occupational therapists take to optimize the effectiveness of their discharge planning skills within the current health care system? Using an action research methodology, two groups of five occupational therapists met online to discuss acute care occupational therapy discharge planning practices, and actions that could be taken to strengthen their practice. Action plans generated, implemented, and evaluated focused on improving communication with discharge planners, language used in documentation, and incorporating the use of standardized assessments to assist with discharge planning. Schell's ecological model of professional reasoning as the theoretical model underlying this study was used to examine factors that influence occupational therapy discharge decision making. Data were collected from audio chat transcripts, survey responses, and researcher notes, and analyzed using Stringer's action research sequential data analysis and interpretation methodology. Five themes emerged including (a) the role of occupational therapy, (b) the

complexity of discharge planning, (c) pragmatics of practice, (d) why don't they pay attention, and (e) the importance of stakeholder communication. Participants felt that discharge planners were not reading occupational therapy documentation, occupational therapy consults were late so that occupational therapy discharge recommendations were just a formality, and physical therapy discharge recommendations had more weight than occupational therapy recommendations. Participants felt that if patients were discharged without benefit of occupational therapy recommendations they could be at increased risk for an adverse event and compromised safety. Good communication among stakeholders was seen as essential for optimal discharge planning.

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Chapter 1: Introduction

Acute care is considered the first stop in the continuum of care and the first stage of rehabilitation after an acute illness or injury. Discharge planning is an important part of acute care practice as patients are often discharged to the next setting with continued medical acuity and many unmet rehabilitation needs (Bowles et al., 2008; Duxbury, DePaul, Alderson, Moreland, & Wilkins, 2012). Discharge planning is also considered a primary aspect of an acute care occupational therapist's job (Blaga & Robertson, 2008).

For acute care occupational therapists, discharge planning is a complex process as it requires good critical reasoning skills, knowledge of health care guidelines and disposition options (and their requirements), and an understanding of client and contextual factors (Hamby, 2011). Optimal occupational therapy discharge decision-making skills can help set the stage to assist patients in realizing their full rehabilitation potential and highest level of independence, which directly impacts patients' quality of life. Conversely poor discharge planning has been associated with poor patient outcomes (Crennan & MacRae, 2010).

Background to the Problem

Discharge planning is a routine part of acute care practice, with the goal of reducing hospital stays, containing costs, and ensuring the provision of coordinated services needed after discharge to reduce unplanned readmissions and improve patient outcomes (Shepherd et al., 2013). Although discharge planning has always been an important part of acute care practice, it has assumed an even greater role with recent

changes in legislation and reimbursement. Hospital practices tend to change in response to changes in payer sources and practices as hospitals want to be reimbursed for their services. “When major changes occur with payment, practice is transformed” (Lohman, 2014, p. 1051). The history, trends, rules, regulations, and provisions of health care and hospital reimbursement systems (including managed care) are extremely complex and beyond the scope of this dissertation. However, it is worth noting that in response to rising health care costs, Medicare instituted the Prospective Payment System (PPS) in the 1980s with other third party payers adopting many PPS pricing strategies (Hyman et al., 2004; Mayes, 2007). Under PPS, hospital reimbursement became a set fee per patient based on his or her diagnostic related group, regardless of actual cost of services (Office of Inspector General, 2001). This encouraged hospitals to shorten hospital stays to decrease costs and to shift rehabilitation to other settings (Lohman, 2014).

With patients being discharged earlier, the thought was that limited health care resources could now benefit larger numbers of people (Hager, 2010), as with larger patient turnover there would be more beds available for new admissions (Atwal & Caldwell, 2002). This created a paradigm shift in which patients no longer remained in the hospital until their medical condition resolved or they stopped improving (Mor & Besdine, 2011). Although there has been an associated increase in readmissions with short hospital stays, there is no evidence that the quality of hospital provided care was compromised (Kalra, Fisher, & Axelrod, 2010). However, patients are now released “quicker and sicker” (Jewell & Schultz, 2010, p. 1), frailer and more vulnerable (especially the elderly) and with more medical and rehabilitation needs than years ago (Durocher, 2014; Hamby, 2011). Consequently, there has also been an increase in the

number of readmissions and adverse events after discharge which may have been preventable or easily remedied with better discharge planning (National Quality Forum [NQF], 2009).

Policy changes in payment for acute and post acute care and their sequelae are widely recognized as contributing to the rising rates of rehospitalization and the increased frequency of transitions among health care setting and teams, particularly during the past decade. (Mor & Besdine, 2011, p. 302)

Readmission rates have been reported as high as 1 in 5 for Medicare patients (Axon & Williams, 2011). A study by Jencks, Williams, and Coleman (2009) found that over 19% of patients were readmitted within one month, and more than one-half were readmitted within a year. Under the Hospital Readmission Reduction Program (HRRP) of the Affordable Care Act (ACA), hospitals must report their readmission rates and are now penalized for having higher than average readmission rates within 30 days (Boccuti & Casillas, 2015; Mor & Besdine, 2011; Roberts & Robinson, 2014). These penalties can include a maximum reduction of up to 1% of their reimbursements from Medicare (i.e., lower payments from Medicare per patient stay; Boccuti & Casillas, 2015; Hogenmiller, 2014). Initially, hospitals were only penalized for frequent readmission of selected diagnoses (e.g., acute myocardial infarction, congestive heart failure, and pneumonia), but the list has now expanded to include chronic obstructive pulmonary disease, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, and other vascular conditions (e.g., stroke; Hogenmiller, 2014).

While the PPS incentivized hospitals to shorten lengths of stay, ACA penalties have incentivized hospitals to reduce readmission rates by putting into place optimal

discharge and transition programs. Comprehensive patient-centered discharge planning is viewed as an essential strategy in reducing rates of readmission, especially for complex medical cases (Medicare Learning Network [MLN], 2014; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Rossi, 2015). There has also been a recent push for hospitals to set up a culture of safety including safe practices in discharge planning (NQF, 2009), so that “patients receive the right care, in the right service location, at the right time” (Coffin-Zadai, 2010, p. 704). In addition, health care organizations are mandated by Medicare to have a discharge plan in place that identifies patients at risk of post-discharge adverse events, indications of patient and family consultation, and a documented discharge assessment by a licensed professional that considers the patient’s ability to engage in self-care as well as the availability of post-discharge services (Hager, 2010).

There is also a push for hospitals to be more patient-centered, with a relatively new Center for Medicare and Medicaid Services ([CMS], 2014a) mandate called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). This is a national survey that patients fill out on their satisfaction and perceptions of their recent hospital experiences. Hospital scores or ratings are publicly reported and compared as an inducement for hospitals to improve their quality of care and to better inform health care consumers.

Occupational therapists can contribute to reducing readmission rates and improving patient satisfaction—two common markers of successful discharge planning. This can be accomplished through discharge recommendations that support patient safety and address patients’ unmet functional and rehabilitation needs. These needs are usually

related to the patient's admitting diagnosis, but also to newly acquired impairments and vulnerabilities associated with hospitalization such as (a) bed rest immobility, (b) associated myopathy, (c) nosocomial infections, (d) pressure ulcers, (e) venous thromboembolism, (f) mental stress, or (g) in hospital falls (Roberts & Robinson, 2014).

According to Roberts and Robinson (2014), there are many ways in which occupational therapists can contribute to readmission prevention including (a) participation in fall prevention programs; (b) skin care teams; (c) readmission task committees; (d) identifying barriers to discharge planning, and communicating to members of the team information about patients' level of cognition; (e) health literacy; and (f) any visual deficits. Therapists working within this setting are considered experts in determining discharge needs and safety (Gorman et al., 2010) and have specific knowledge and skills which guide their recommendations. This would make occupational therapists ideal members of transition teams, which are now predominantly within the domain of nursing.

Statement of the Problem

Discharge planning is an essential part of the job requirements for occupational therapists who work in the acute care setting, but this process can be challenging and difficult. There are a multitude of factors that need to be considered—both internal and external—that often pose barriers to optimal discharge planning, especially when therapists have to work within parameters where they have little control (e.g., reimbursement issues). Compounding the problem, there are no clear guidelines for therapists to follow given the number of challenges they face when striving for comprehensive and effective discharge planning.

The following section briefly reviews some of the more common challenges for therapists including (a) time issues, (b) reimbursement, (c) lack of standardized assessments, (d) ethical conflicts, (e) constrained practice, (f) context of home versus the hospital environment, (g) issues of client-centeredness, and (h) working within a medical model system. Many of these concerns are discussed more in depth in Chapter 2.

Time Issues

For acute care occupational therapists, “time is a rare commodity” (Belice & McGovern-Denk, 2002, p. 24) as therapists work in a fast-paced environment with an extensive caseload and limited time to communicate with other staff members, write documentation, and complete other job related responsibilities. In addition, therapists often feel pressured to make quick decisions about patients’ needs (Blaga & Robertson, 2008; Kasinskas, Koch, & Wood, 2009; Moats & Doble, 2006) based on the patient’s “snapshot in time” (Clark & Dyer, 1998, p. 38). However, premature discharge recommendations can be inappropriate causing further stress to the patient, family, and therapist (Durocher, 2014).

In many cases, time issues are related to limited patient-therapist interaction time as consults are often received the day before or the day of discharge, as a final step in verifying the discharge disposition or for insurance purposes (Kasinskas et al., 2009). This does not help patients who may have benefited from an earlier consult or a longer hospital stay in which they would have had the opportunity to begin their rehabilitation journey and be better prepared at the time of discharge (Crum, 2011; Durocher, 2014; Kasinskas et al., 2009).

Last minute therapy consults also illustrate how the acute care therapy model of *assessment-intervention-discharge* has been supplanted by an *assessment-discharge* model (Craig, Robertson, & Milligan, 2004). Patients are often only seen for an occupational therapy consult and are then discharged from the hospital. Therapists want to ensure that a discharge plan is put in place that is thoughtful, comprehensive, and meets the patient's safety and discharge needs; yet, therapists have limited access to patients and a short amount of time in which to formulate their recommendations (Durocher, 2014; Kasinskas et al., 2009; McKelvey, 2004), as the average length of an acute care stay is approximately two to three days (MLN, 2014).

Limited time with patients is not just a factor of late consults. Very often time is limited as the therapist is unable to meet with the patient because the patient is working with other services, the patient may be off the floor for a test or procedure, the patient may refuse as he/she is not feeling well, or the patient's presentation changed and participation in therapy is no longer appropriate. In addition, large caseloads also make it difficult for therapists to see everyone on their caseload with the desired or ordered frequency, and stress from productivity expectations may have therapists alter the amount of time they spend with patients or the activities they engage in. For example, an initial evaluation usually generates a fixed amount of billable units. In order to meet productivity, therapists are incentivized to complete evaluations in the least amount of time, further limiting direct patient-therapist interaction time.

Reimbursement

Funding policies determine health care and patient costs, length of stay, type of care that is available and for how long, and what discharge options are available

(Durocher, 2014). The type of health care coverage that is available can severely limit or restrict the discharge options that are available to patients, and can influence patient and family acceptance of recommendations, regardless of the patient's needs. "Funding policies for care outside of the hospital may therefore have a direct impact on the outcomes of discharge planning from inpatient care services" (Durocher, 2014, p. 28). Knowledge of disposition eligibility and coverage directly affects discharge planning and recommendations. A therapist may feel a patient can benefit from a certain follow-up service, but without the financial resources or insurance coverage that patient will likely not receive the recommended or needed service.

Standardized Assessments

Occupational therapy literature on discharge planning in acute care advocates for the use of standardized assessments to assist with predicting disposition, but acknowledges that most assessments are informal or performance based (Blaga & Robertson, 2008; Crennan & MacRae, 2010; Jette et al., 2014; Matmari, Uyeno, & Heck, 2014; Robertson & Blaga, 2013). There are assessment tools that have predictive value that acute care occupational therapists would find beneficial (e.g., Assessment of Motor and Process Skills), however they are not utilized as they take too long to administer, they cannot be administered within the confines of a patient's hospital room, they may be costly, or require training that takes away from precious time. Therefore, although most therapists support the need for standardized assessments, the majority of occupational therapists do not use them as they interfere with productivity standards, more so than informal methods (Jette, Grover, & Keck, 2003).

In addition, there is no single comprehensive discharge assessment found in the literature that encompasses the diversity of medical conditions, and that can assist acute care occupational therapists in making their recommendations (Crennan & MacRae, 2010). For example, there are several studies that have examined factors and assessments that are predictive of discharge disposition. These studies were generally based on specific diagnoses (e.g., stroke, hip fracture/hip replacement, and dementia), functional ability (e.g., mobility, basic and instrumental activities of daily living, and cognition), demographics (e.g., age, socioeconomic status, family or caregiver support, home set up, and living situation), presence of chronic conditions or co-morbidities, pain, finances, patient's insurance (or lack of), and health care policies and procedures (Jette et al., 2003). However, these assessments are often of limited usefulness for individual patients or are not generalizable as they are specific to institutions, or they do not cover the diversity of elements that need to be considered (Jette et al., 2003). Several of these studies will be further discussed in Chapter 2.

Ethical Conflicts

There is much in the literature about occupational therapy discharge planning and the code of ethics, especially with older patients. These types of conflicts usually revolve around conflicting priorities and issues of patient autonomy versus risk avoidance. For example, a patient may want to be discharged back to their home where he or she lives alone, while the discharge planning team concerned about the patient's safety recommends a different disposition. In this way, the discharge planning team may be going against the patient's wishes and violating his or her autonomy. There can also be an

ethical conflict when the therapist, patient, and family are in agreement about disposition, but it conflicts with health care regulations or reimbursement sources.

Constrained Practice

According to Nalette (2010), the manner in which patients' needs are assessed is determined by the profession's models or frames of reference for practice, and meeting those needs requires therapist expertise, moral courage, health care resources, laws, regulations, and a supportive organizational culture. Nonetheless, therapists' practice can be constrained by these same factors when they are put in the position of having to support a less effective and perhaps unethical plan (Nalette, 2010). There are numerous references in the literature and anecdotally by therapists of how internal and external factors can create barriers to therapist autonomy, and their ability to provide caring client-centered practice. A typical example is a patient who needs intensive acute inpatient rehabilitation but because of insurance coverage, the disposition instead is home with bi-weekly home health therapy. Another example would be a patient who can benefit from an inpatient acute rehabilitation stay but is also not accepted as he or she does not have one of the medical diagnoses that falls within Medicare's list of 13 conditions (Center for Medicare and Medicaid Services [CMS], 2014b) for an inpatient rehabilitation facility (IRF) admission, and the facility has already reached their case-mix quota. These scenarios also bring into question issues of occupational justice (American Occupational Therapy Association [AOTA], 2015), where some patients are able to receive needed care, but others are denied.

Utility of Pre-Discharge Home Assessment

Another area of concern is that acute care occupational therapists are expected to make judgments about the clients' readiness to return home safely, without being able to observe the patients in their natural environment or context. It is important to keep in mind that occupations engaged in while hospitalized may not be the same occupations performed at home, or that the patients' occupational performances may have changed temporarily or permanently as a consequence of their hospital experience and any medical or surgical interventions (Belice & McGovern-Denk, 2002). The patient's presentation may also be markedly different from admission to discharge. This adds to the challenge that acute care occupational therapists have in trying to determine their patients' occupational readiness to safely return home.

Optimally, if therapists could perform pre-discharge home visits, it could provide essential information needed to best prepare patients for discharge. Functional assessments conducted in the patients' home environment are also better determinants of older patients' needs, than either subjective patient self-assessments or hospital-based assessments (Boronowski, Shorter, & Miller, 2012).

Much of the occupational therapy literature on acute care discharge planning focuses on the utility of pre-discharge home visits (Chibnall, 2011; Harris, James, & Snow, 2008; Lannin, Clemson, & McCluskey, 2011). However, the benefits of pre-discharge home visits are of limited value to the present study as the research was conducted in other countries with different health care systems. In addition, in the United States many patients live far from the hospital and therapists are not allowed the time or budget for pre-discharge home visits (Clark & Dyer, 1998; Crennan & MacRae, 2010).

Challenges to Client-Centeredness

Poor discharge planning including patients' perceived lack of consultation has been associated with poorer outcomes, while effective discharge planning is client centered and associated with good communication between all stakeholders (Crennan & MacRae, 2010; Parker et al., 2002). Despite client centeredness being a core value of occupational therapy, research has shown there are often differing expectations and perceptions of client-centered practice between patients and therapists, with acute care occupational therapists having the greatest difficulty in being client centered (Maitra & Erway, 2006). To be client-centered, therapists need to consider the *expressed* needs of their patients, not just what they determine are the *assumed* needs based on the patient's assessment results (Duxbury et al., 2012). Therapists may also feel conflicted as they want to make patient-centered discharge recommendations, but have obligations to the rules and regulations of the hospital that employs them, which can be in conflict with their patient's wishes.

Delivering Holistic Care in a Medical Model Setting

Another issue that may be difficult for acute care therapists is the philosophical differences between occupational therapy and the medical model system of the acute care practice setting. Occupational therapy views itself as a health profession that values a holistic approach to patient care while the medical model tends to be reductionist with a focus on illness, injury, and physiologic function.

Although it is recognized that their role in ensuring safe hospital discharge is important and cost-effective when properly organized, occupational therapists are unwilling (and often powerless) partners in a system that focuses on rapid

discharge rather than reducing dependence and dysfunction. (Roberston & Finlay, 2007, p. 74)

In a hierarchical medical model system, there are also power differentials where the locus of control lies with physicians (Coffin-Zadai, 2010; Connolly et al., 2009; Moats, 2006) or case managers with limited to no input from occupational therapy (Craig et al., 2004). The input of therapists is necessary as demonstrated in a physical therapy study that found that readmission rates were almost 3 times higher when the discharge disposition did not follow physical therapy recommendations (Smith, Fields, & Fernandez, 2010).

Within acute care, there also seems to be a greater reliance on physical therapy documentation and recommendations than occupational therapy documentation (Huby, Brook, Thompson, & Tierney, 2007) with some occupational therapists feeling misunderstood and disrespected (Craig et al., 2004). In addition, many hospital patients remain confused about the differences between occupational and physical therapy services (Brown, Craddock, & Greenyer, 2012) and have a lack of understanding of how occupational therapy can benefit them (Maitra & Erway, 2006). This may contribute to the lack of press for occupational therapy, and for occupational therapists to be regularly consulted in a timely manner for their input in discharge planning. As a result, occupational therapy may be an underutilized resource.

In addition, 26% of discharged patients return home with unmet needs related to self-care, environmental barriers, or lack of available skilled caregivers (Bowles et al., 2008). This is an important issue, especially for older patients who increasingly rely on an acute health care system that is not equipped to address their chronic needs (Hickman,

Newton, Halcomb, Chang, & Davidson, 2007). Discharges that address patient needs may reduce the risk of post-discharge adverse events, facilitate increased independence and safety, as well as decrease caregiver burden. “We know that caregiver burden is lessened if the patient leaves the hospital at a moderate assistance level of care rather than at a total assist level” (McKelvey, 2004, p. CE-6).

Despite all these issues and challenges, acute care therapists are uniquely qualified to help determine the most appropriate discharge destination for patients (Jette et al., 2014). They accomplish this by assessing whether patients are safe to go home, alone or with family and/or community support, and whether any follow-up therapy or other services, equipment or home modifications are needed to support performance at home. Acute care occupational therapists also consider whether patients are cognitively intact, have good safety awareness, and are aware of any new or prior limitations that now impact their ability to safely engage in occupations.

Acute care therapists work in a practice setting with “complex environmental influences as well as fluctuating physiologic presentations of patients” (Gorman et al., 2010, p. 1457). In order to make an effective discharge plan within this challenging environment, therapists need to (a) recognize the limitations of patients with complex medical conditions; (b) have knowledge about pathophysiology, prognosis, symptoms, precautions, contraindications, and medical and surgical management, and their side effects; (c) be knowledgeable about the effects of illness on multiple body systems across the life span, and (d) implement practices that prevent secondary complications.

Therapists must also be skilled in communication, documentation, and have the ability to quickly develop an individualized evidence-based plan of care (Gorman et al.,

2010). In acute care, therapists have a multisystem focus that is holistic as they consider not just the individual body part affected, but also other body systems and overall level of functioning (Masley, Havrillko, Mahnensmith, Aubert, & Jette, 2011). In this setting, occupational therapists need the ability to quickly integrate large amounts of information and employ their professional reasoning skills in addressing barriers and formulating comprehensive discharge recommendations.

Based on the issues and barriers identified above it is understandable that the literature describes discharge planning as a complex process which involves ethical, social, and financial challenges—which are becoming even more evident with the increased admission and readmission of an aging population. However, according to Petersson, Springett, and Blomqvist (2009) there is limited research on the quality of the actual process. For example, research concerning the quality of discharge planning primarily focuses on hospital readmission rates and patient satisfaction surveys, which may or may not reflect on occupational therapy practices. There is also limited information on the quality or appropriateness of acute care occupational therapists' discharge recommendations or the professional reasoning processes (or combination of processes) that are best suited for making client-centered discharge recommendations in this setting.

Despite the multitude of studies over the decades related to different aspects of discharge planning practices, what is missing is the implementation of study recommendations and their evaluation by the very clinicians who have a direct interest in their outcomes. What is also missing and what may benefit therapists, are guidelines for

discharge planning and recommendations that are more responsive to patient and caregiver needs, within a system that is not always patient focused.

Purpose of the Study

The purpose of this study was to examine how acute care therapists in the United States engage in the discharge planning process, what strategies they are currently using, and what new approaches they can develop to improve the quality of this process including overcoming obstacles related to effective client-centered discharge planning. Using a qualitative action research design, the participants in the study generated and implemented plans of action, and then evaluated the effectiveness of their action plans in their own practice settings.

An intentional goal in conducting this action research study was to generate knowledge of how occupational therapists can improve their participation, competence, and confidence in the discharge planning process through a collaborative action research approach. The hope was that in the process of examining acute care occupational therapy discharge planning practices, more information to develop best practice guidelines would surface.

Research Questions

- How do acute care occupational therapists describe their role in the discharge planning process?
- What guides acute care occupational therapists discharge decisions and recommendations?
- How do acute care occupational therapists define optimal discharge planning?

- What actions can acute care occupational therapists take to optimize the effectiveness of their discharge planning skills within the current health care system?

Definition of Terms

- *Adverse event* is when the patient is unintentionally harmed due to unmet needs at the time of discharge, resulting in a hospital readmission.
- *Client-centeredness* in this study refers to ascertaining clients' preferred discharge disposition, and communicating their wishes and needs to other stakeholders.
- *Constrained practice* is a moral dilemma in which the therapist recognizes the legitimate needs of the patient, but must put in place a less effective plan due to internal or external factors (e.g., lack of insurance coverage; Nalette, 2010).
- *Discharge disposition* is the setting patients are discharged to after they leave the hospital. This may include a stay at an acute IRF, subacute rehabilitation, or long-term acute care stay, rehabilitation day program, hospice, nursing home, or home with or without environmental modifications, durable medical equipment/adaptive equipment, home health therapies, home health assistance, caregiver assistance, or outpatient therapy.
- *Discharge planning* includes activities that help transition a patient back to home or to another health care setting. In this study, discharge planning is a process based on multidisciplinary collaboration and the contributions of occupational therapy, which attempts to ensure that patients' needs will be met, whatever their ultimate discharge setting (Atwal & Caldwell, 2003a).

- *Discharge decision making* is the process that involves the therapist's professional reasoning, knowledge, and expertise in formulating discharge recommendations.
- *Discharge recommendations* are a suggested course of action to ensure a smooth transition with a patient's release from the hospital. In this study, discharge recommendations will be the therapists' indication of the preferred or chosen discharge setting for patients. These can include home (with or without assistance, modifications, and/or equipment), inpatient rehabilitation, hospice, or nursing home placement.
- *Professional reasoning* is the process that a profession uses to form conclusions that direct action. In this study, professional reasoning is defined as a process that involves using available information and experience in making judgments that inform occupational therapy clinical decisions in the acute care setting. Often therapists use as specific type or combination of reasoning processes depending on the problems they are attempting to solve.
- *Therapy actions* are the result of interplay between the intrinsic factors of the therapist and the client, and the external factors of the practice context. In this study, therapy actions refers to the implementation and evaluation of the action plans decided on through consensus of the action research group.

Rationale and Need for Study

Within acute care settings occupational therapists work with patients with serious and diverse medical conditions and holistically help them restore function and/or prevent further decline (American Occupational Therapy Association [AOTA], 2012). The primary role for occupational therapists within this setting is patient assessment,

discharge planning, and to a lesser extent therapeutic intervention. The goal of discharge planning is to determine the best setting or disposition for the patient, one that is least restrictive but prevents falls or other adverse events. The discharge plan should also support or facilitate the patient's highest level of independence, rehabilitation, and safety. By most accounts, discharge planning is a challenging and complex process with no clear guidelines to assist therapists with the process. However, occupational therapists can fill an essential role by broadly considering, "the context and other factors that affect health, especially integration of daily habits and routines improving function and safety of patients as they return home" (Roberts & Robinson, 2014, p. 255).

As occupational therapy discharge recommendations can have a significant impact on issues of patient safety, autonomy, rehabilitation potential, and quality of life, it is important to discover what therapists are currently doing, what discharge practices are successful, and which are ineffective or may be unintentionally harmful. It would also be helpful to know what changes acute care occupational therapists felt needed to be made to improve the process, and what would be feasible and realistic considering the many barriers they encounter in routine practice in this setting. The underlying reason to explore these questions is that just as poor discharge planning has been linked to poor patient outcomes (Crennan & MacRae, 2010), then conversely improved discharge planning practices can potentially result in improved patient outcomes with reduced rates of readmission and adverse events, and greater patient satisfaction.

It is important to look for ways to improve the discharge planning process and ensure that therapists *get it right*, as discharge decisions can have a profound effect on patients' lives and as they continue through the continuum of care. Therapists can benefit from strategies that would help in determining patient safety and occupational readiness to return home in the absence of pre-discharge home visits—which are not part of routine practice in the United States—and without an over-reliance on risk avoidance or at the expense of patient autonomy.

Findings from this study are also expected to contribute to practice by improving communication between occupational therapists and other team members. Good communication is essential for coordinated discharge planning and is associated with better patient outcomes (Craig et al., 2004; Crennan & McRae, 2010; Hickman et al., 2007; Nosbusch, Weiss, & Bobay, 2010; Pethybridge, 2004). Good communication includes using effective language in documentation and when collaborating with other stakeholders. It is expected that language discussed in this study will enrich the participants' communication with other stakeholders. It would also be helpful if acute care occupational therapists consistently helped patients and other stakeholders better understand the implications of discharge decisions and recommendations.

Improved communication may also help increase awareness of occupational therapy's contributions to the discharge planning process, and increase participants' confidence that the services they provide are supported and valued. As respect is an area of concern for acute care therapists (Craig et al., 2004), they need the ability to communicate and articulate the reasoning and evidence that underlies their approaches

so they can justify their clinical decisions to others (Wilding & Whiteford, 2007); thereby, raising their profile and visibility.

There is also a percentage of patients who are discharged from hospitals with unmet needs, which increases their risk of post-discharge adverse events and readmissions (Duxbury et al., 2012; Luker & Grimmer-Somers, 2009; Mistiaen, Francke, & Poot, 2007). This warrants the need for better assessment tools that are more predictive of post-discharge needs. As such, discharge planning could be improved through the use of standardized assessments as a method to improve the accuracy of discharge recommendations.

In addition, there is a great deal of interest expressed by acute care occupational therapists in the literature and anecdotally to incorporate standardized assessments into routine practice. The expectation was that participants in this study would address this need by advocating for the use of an established standardized assessment(s) or develop a new assessment or discharge checklist. There is also the need for a discharge planning tool that encompasses the diversity of conditions and populations seen in the acute care setting as currently there are none available. In addressing the need for better predictive tools, there was the expectation that the group would develop a discharge planning model (e.g., discharge algorithm or decision tree) to assist in making more accurate, comprehensive, and client-centered recommendations.

As currently there are no set guidelines for acute care discharge planning there is moreover the need for the development of best practice guidelines. The findings of this study could highlight what acute care therapists feel are important, which could spur further research into acute care occupational therapy discharge planning practices and

form the basis for the development of best practice guidelines. In addition, it may help therapists articulate a consensus definition of optimal discharge planning that would further define the roles and goals of occupational therapy in the acute care setting. It was also expected that participation in this study would broaden participants' understanding of their practice through discussion and reflection, which would empower them to make changes in practice.

At present there is no specialty section or group for acute care therapists within the American Occupational Therapy Association (AOTA), with the exception of the website OT Connections (<https://otconnections.aota.org/>) dedicated to acute care practice. However, this site is restricted to AOTA members and one must log in to the site in order to access it. There are many pragmatic issues and barriers that need to be addressed to effectively practice within the acute care setting. Acute care is a very unique environment with its fast pace, quick discharges, medically complex patients, reliance on equipment and devices, reimbursement issues, and where therapists are expected to rapidly make discharge decisions based on limited information or limited face-to-face time with patients. Acute care therapists could benefit from a forum or its own community of practice where these issues could be discussed, ideas and strategies shared, and support provided. This would bolster the confidence, resources, and perhaps competence of therapists, which could ultimately translate into better outcomes for patients.

The format of this study as a repeated online meeting of occupational therapists who practice in acute care and who are from different geographic areas provided such a forum, despite being limited to only several weeks. However, this study laid the ground

work and had the potential for the groups to continue to dialogue even after the conclusion of the study. In addition, the findings of this study could contribute a better understanding of the occupational therapy *professional lens* and community of practice attitudes and beliefs of acute care occupational therapists, in line with Schell's ecological model of professional reasoning (Schell, 2014).

The above are some of the issues explored during the course of this study, with approaches to address some of these problems formulated through the action research process. The discharge planning process is often complex and confusing, involving systems and stakeholders with conflicting interests. Occupational therapists do not have the final say in determining discharge dispositions but they can *make the difference* and be instrumental in facilitating a patient's safe return home rather than a different setting (McKelvey, 2004). Within an acute care setting the focus of medical staff is on preserving life, but occupational therapists promote living it, once the medical crisis is resolved. "Occupational therapy can add value by encouraging attentions to the broader issues of how persons survive when they leave the hospital setting" (Roberts & Robinson, 2014, p. 255).

Theoretical Framework for the Study

Professional reasoning is an integral part of the clinical decision-making process. Clinicians in acute care require a complex, sophisticated, and high level of problem solving in analyzing and synthesizing patient information for discharge decision making (Jette et al., 2003; Masley et al., 2011). Due to the complex and dynamic nature of the acute care environment, the unpredictability and diversity of the patient population, discharge decision making requires a flexibility of thought, continual assessment, and

professional reasoning skills that inform clinical decisions about patient care “on a moment-to-moment, within-session basis as well as over the entire episode of care” (Masley et al., 2011, p. 913). Therefore, the application of a professional reasoning model would be useful in the study of how therapists go about the process of making recommendations related to discharge planning.

The theoretical framework for this study is Schell’s ecological model of professional reasoning (Schell, 2014), which links the process of professional reasoning to therapy action. According to Schell’s ecological model, professional reasoning is influenced by both intrinsic factors of the therapist and client, and extrinsic factors of the practice context, with therapy action as the outcome of the interplay between them (Schell, Unsworth, & Schell, 2008).

Assumptions and Limitations

This study assumes that acute care occupational therapists are members of a multidisciplinary team who contribute to the discharge planning process, are client centered and ethical, and have the requisite knowledge, experience, and professional reasoning skills to make appropriate discharge recommendations for their patients. There is also the assumption that improving acute care occupational therapists’ discharge planning skills will result in improved patient outcomes. Limitations may include limited researcher control as the direction of this type of research is unpredictable, and results although transferable, cannot be generalized to other groups. In addition, it will remain unknown how accurate or effective occupational therapists’ recommendations are to their patients’ ultimate rehabilitation.

Summary

In today's health care environment of shortened hospital stays, patients are often unable to stay within the hospital setting until rehabilitation is complete (Hamby, 2011; Kasinskas et al., 2009; Mor & Besdine, 2011). As a result, rehabilitation must continue at a different setting, and as such discharge planning in acute care has taken on added importance. Unfortunately, occupational therapists often have limited time to spend with patients to get to know them, determine their needs, develop an occupational profile, and make the most appropriate recommendation for discharge disposition.

In this study an action research approach was undertaken to answer the questions of how acute care occupational therapists describe their role in the discharge planning process, what factors guide their discharge decision making, how they define optimal discharge planning, and what actions can they take to optimize the effectiveness of their discharge planning skills within the current health care system. Several action plans were implemented and evaluated with mixed results, which are discussed in Chapter 5.

Discharge planning remains an extremely complex process that takes into consideration many internal and external factors, which can support or constrain occupational therapy discharge decision-making. Optimizing acute care occupational therapy discharge planning skills can improve patients' quality of life, satisfaction with their acute care experience, assist patients in resuming cherished roles and routines, and has the potential to prevent adverse events that can lead to readmission.

Chapter 2: Selected Review of the Literature

This chapter provides a selected literature review on research related to acute care discharge planning, Schell's ecological model of professional reasoning (Schell, 2014) as the theoretical framework underlying this study, and literature on occupational therapy action research as the selected methodology for this study. In an effort to find literature on acute care discharge planning, CINAHL, PubMed, EMBASE, OT Seeker, and Proquest Nursing and Allied Health Source were all searched using the following search terms and keywords: *occupational therapy* and/or *physical therapy* + *acute care* + *discharge*, *discharge planning*, *discharge recommendations*, *discharge decision making*, *prediction* + *hospital discharge*, *discharge planning* + *tools*. Replacing *hospital* with *acute care* provided hundreds of unrelated articles and therefore, was not an effective keyword. OT Search was also searched but *occupational therapy* and *physical therapy* search terms were omitted as it was assumed that material contained in this database was already related to occupational therapy. Potential resources were also culled from reference lists of reviewed articles.

In addition, only articles pertaining to adults in acute care and articles written within the past 11 years (2004-2015) were searched. This limited timeframe was selected even though the prospective payment system (PPS) has been in place since the 1980s. It was felt that it has been within the past decade that discharge planning has taken on even greater importance with shortened hospital stays, and will continue to evolve as different mandates of the Patient Protection and Affordable Care Act (U.S. Department of Health

and Human Services, 2014) are enacted. For example, as noted in Chapter 1, Medicare's list of diagnoses that will be penalized for frequent readmissions is continuing to expand (Hogenmiller, 2014). This in turn can further affect discharge planning and transition of care practices. Articles specifically focusing on pre-discharge home visits, the elderly, specific diagnoses, articles prior to 2004, and discharge planning in other professions were also not included unless they supplied essential information related to discharge planning and this study. Physical therapy literature was searched in addition to occupational therapy literature as the two professions work closely together in acute care, are highly integrated in providing rehabilitation services, and share similar discharge decision-making approaches (Jette et al., 2003). However, articles that focused specifically on PT discharge interventions were not included. Refer to Table 2.1 for a list of studies reviewed and their findings.

The Nature of Acute Care Discharge Planning

In the literature, there is a multitude of articles spanning decades about issues related to hospital discharge planning practices. Every year new articles appear, illustrating how this is a timely topic of interest for multiple professions across different countries with continuous examination of various aspects of the process (Blaga & Robertson, 2008; Campbell et al., 2005; Duxbury et al., 2012; Luker & Grimmer-Somers, 2009; Mukotekwa & Carson, 2007; Soskolne, Kaplan, Ben-Shahar, Stanger, & Auslander, 2010).

Within the current system of reimbursement in the provision of health care, the practice has been for hospitals to contain costs and curtail their expenditures by shifting the responsibility for patient care to other cost centers (e.g., community-based programs

and therapy services; Soskolne et al., 2010). Unfortunately, this has led to a corresponding increase in post-discharge adverse events and hospital readmissions (NQF, 2009). Readmissions are expensive and reflect poorly on the hospital's quality of coordinated care. Discharges or *transitions of care* often do not go smoothly and have been described as an “unsystematic, nonstandardized, fragmented process” (NQF, 2009, p. 175). Poor discharge planning has been associated with poor communication between stakeholders, unclear discharge instructions, patients and caregivers being excluded from the process, patients not understanding or buying into the plan, uncoordinated care, and a breakdown in accountability (NQF, 2009; Joint Commission, 2012). As a consequence, discharge planning in the acute care setting has become a “critical activity” (Soskolne et al., 2010, p. 368) with the aim of ensuring a smooth hospital to home transition, improved patient outcomes, and continued post-discharge care if needed (Soskolne et al., 2010).

In addition, technological advances have made it possible to sustain life and as a result society now has increased expectations of medicine and health care because of these advances (Mukotekwa & Carson, 2007). However, these advances have led to more complex areas needing to be addressed in discharge planning, further challenging the process (Mukotekwa & Carson, 2007).

Role of Acute Care Therapists

As hospital stays are short, the therapist's role is becoming increasingly one of an assessor and discharge planner, rather than provider of rehabilitation services (Blaga & Robertson, 2008). For example, in a pilot study that explored the nature of occupational therapy practice in acute physical health care settings in New Zealand, participants felt that the occupational therapy model of care has changed from assessment-intervention-

discharge to assessment-discharge (Craig et al., 2004). This was supported by a later New Zealand study of the nature of occupational therapy acute care practice in which many respondents felt intervention and discharge planning were often considered as one (Blaga & Robertson, 2008). This shift was attributed to the fast pace of the acute care environment with its quick discharges, where one respondent reflected that there is only time for discharge planning and nothing more.

Participants of other studies saw the role of acute care occupational therapists as relegated to activities of daily living (ADLs), but also saw themselves as fulfilling an important function of ensuring a safe discharge including follow-up services and equipment recommendations, and helping to safely bridge the transition from hospital to home (Craig et al., 2004; Holm & Mu, 2012; Robertson & Finlay, 2007). More than one-third of the respondents in Blaga and Robertson's (2008) survey study felt that occupational therapists unlike other members of the team actively listens to patients and families' concerns, and were more holistic as they focused more on abilities and not disability. According to responses to a national physical therapy survey the role of acute care physical therapy includes advocating and helping patients and families navigate through the hospital experience, and helping to prevent secondary complications (Gorman et al., 2010).

Knowledge, Skills, and Abilities of the Therapist

In addition to the above mentioned roles therapists must also have a certain level of knowledge, expertise, and experience to make appropriate and effective discharge recommendations. Discharge planning is unique in this setting because routine practice

consists of quick patient turnover, a medically oriented focus, pressure for fast delivery of health care services and rapid decision making (Robertson & Blaga, 2013).

Occupational therapists and physical therapists working in acute care often work with the same patients, so both professions need similar knowledge and skills to function effectively in this practice setting. In a national physical therapy survey study of the knowledge, skills and behaviors required for acute care practice, they found that acute care physical therapists require knowledge of the impact of acute and chronic conditions and medical/surgical interventions on body systems, as well as knowledge of the different discharge dispositions and their criteria (Gorman et al., 2010). In addition, therapists needed to be knowledgeable about the potential impact of context specific demands on patients, as well as limitations set by Medicare and other third party payers (e.g., patients must be deemed *homebound* in order to receive home health services; Gorman et al., 2010). Respondents indicated that acute care clinicians need a “depth and breadth of knowledge specific for acute care and patients with acute illnesses throughout the life span and across multiple body systems” (Gorman et al., 2010, p. 1457), and must be prepared to work with patients that are medically fragile, and have medically complex conditions that can be unpredictable (Gorman et al., 2010).

Acute care therapists require skills to quickly integrate large amounts of information and employ high level sophisticated clinical reasoning skills in performing their jobs in the acute care setting (Gorman et al., 2010; Masley et al., 2011). Therapists also have to be flexible in their thought processes, as therapists have to rapidly adjust to changes in patient presentation. In a grounded theory study that explored the role of acute care physical therapy, the researchers found that acute care physical therapists require

skills in which they modify their evaluations, interventions, and goals as a moment to moment process based on the patient's response to their treatment or changes in their presentation (Masley et al., 2011). Decision making is done on both a micro and macro level, as in addition to having knowledge about a patient's medical condition therapists must also have an understanding of any precautions, contraindications, the effects of medications, symptoms, normal and abnormal responses to treatment sessions as well as recognition of any red flags (Masley et al., 2011).

In another survey study about the role of acute care physical therapists, respondents indicated that acute care physical therapists need knowledge of the various discharge destinations, knowledge of clients' needs, and what can be provided to patients at discharge institutions (Kasinskas et al., 2009). Occupational therapists need the same knowledge about discharge settings as physical therapy, but also need to know whether their patients have the occupational performance skills to function within the demands of the recommended environment.

For effective discharge planning acute care occupational therapists also need a good understanding of their role in the acute care practice setting, including knowledge of theories to support practice, a broad knowledge of diagnoses, and the ability to clearly articulate the reasoning supporting their clinical decisions (Craig et al., 2004). According to the survey study referenced above that examined the nature of occupational therapy acute care practice in New Zealand, more than one-half of respondents stated the theoretical framework that informally guided their practice and decision making was the Canadian model of occupational performance (36 respondents; Law et al., 1990) and a biomedical compensatory or rehabilitation model (27 respondents), followed by the

model of human occupation (20 respondents; Kielhofner & Nichol, 1989; Blaga & Robertson, 2008).

There has also been an interest in the accuracy of therapist recommendations. In a large retrospective study on the accuracy of acute care physical therapy discharge recommendations, physical therapists' recommendations were matched 83% of the time, and were therefore deemed accurate (Smith et al., 2010). In addition, when physical therapy recommendations were not implemented and no follow up services were available to patients, there was an almost 3 times increased risk of hospital readmission. Another large retrospective study also found an 83% accuracy rate or match between occupational and physical therapy discharge recommendations and actual discharge dispositions (Jette et al., 2014).

Clinical Reasoning

Clinical and professional reasoning skills of therapists are an essential component of discharge decision making, as therapists consider myriad factors in putting pieces together to make recommendations that best fit patients and their circumstances. Well developed clinical reasoning skills are needed to meet the individual discharge needs of each patient (Holm & Mu, 2012). Studies on reasoning processes and discharge decision making help us better understand the link between knowledge and therapy action, especially in relation to therapy outcomes. Acute care therapists' critical reasoning has been found to be strongly challenged by hospital short lengths of stay, limited time with patients, reimbursement issues (e.g., insurance), and criteria for inpatient rehabilitation admittance that limit which discharge options can be considered (Jette et al., 2003).

Therapists' clinical reasoning skills plays a vital role in discharge planning, as more comprehensive discharge decision making practices have been found to be related to the level of experience of the clinician (Holm & Mu, 2012). In a phenomenological study that explored the perceptions of experienced acute care occupational therapists and factors they considered in discharge planning for the older patient, they found that the discharge planning skills of experienced therapists were more highly developed than novices (Holm & Mu, 2012). This was largely due to experienced therapists considering information from multiple sources, including information about the clients' occupations and roles, recovery potential, information about the home environment and support systems, and access to community resources. In addition, they sought explanations for why patients were failing to thrive at home, and noted any undiagnosed cognitive or psychological impairments. Experienced therapists were also better equipped to anticipate potential safety issues and concerns including a history of falls, age related visual and other sensory deficits, and patients' reduced insight into present level of functioning and safety awareness.

As expected novice therapists have less developed critical reasoning skills on which to formulate patient discharge recommendations. Novice therapists also have more difficulty in making the rapid decisions that need to be made in the time pressured environment of the acute care setting (Holm & Mu, 2012; Robertson & Blaga, 2013). Novice therapists lack the experience and professional judgment of experienced therapists, who have more mental flexibility, can draw on past experiences, are more confident in their knowledge, and are more intuitive in making discharge

recommendations. Less experienced therapists are also more conservative in their recommendations and tend to rely more on the opinions of others (Jette et al., 2003).

In a qualitative study that explored institutional factors that influenced discharge decision making related to older patients, the researcher found that most of the occupational therapists in the study tended to use a mixed decision-making approach (e.g., risk avoidance versus autonomy; Moats, 2006). Moats and Doble (2006) in their article on discharge planning and older adults proposed a new model for decision making that is based on negotiation and partnership with patients. However, they felt the challenge is in finding ways to make negotiated discharge decisions despite the time constraints in acute care by incorporating “strategies into the already existing fast-paced, rigid, decision-making structures in the hospital...limited in their practices by regulations” (Moats & Doble, 2006, p. 309).

In a seminal study of acute care clinician discharge decision making, Jette et al. (2003) used a grounded theory approach to examine the processes that acute care occupational and physical therapists use when making discharge recommendations. Based on their data they developed a model of decision making that consisted of four constructs: patient’s level of function and disability, patient’s wants and needs, patient’s ability to participate, and patient context of life. As part of their model the researchers suggest that information pertinent to discharge decision making is filtered through the therapist’s lens of their experience and adjusted by knowledge of health care regulations/policies, and input from other team members. Jette et al. (2003) cited Eisenberg (1979) who proposed that the shared interaction between patient and therapist develops into a socially constructed system in which clinical decision making takes place.

Jette et al. (2003) also found that occupational therapy and physical therapy have a similar approach to professional reasoning in relation to discharge decision making. Jette et al.'s model adds to our understanding of the complex process of discharge decision making, and the importance of therapists' critical reasoning skills in making meaningful discharge recommendations.

The most well-known occupational therapy study on critical reasoning was the AOTA and the American Occupational Therapy Foundation (AOTF) Clinical Reasoning Study (Mattingly & Fleming, 1994), which found that critical reasoning used by occupational therapists involved different types of thinking including tacit knowledge and a combination of four different types of reasoning processes—procedural, interactive, conditional, and narrative. This ethnographic and action research study suggests that therapists engaged in *underground practice*, addressing client practice issues that were not biomedical. Mattingly and Fleming also portray the hospital as a *transitional world* for clients before returning to the community, with occupational therapists as the transporters. This study and the different types of professional reasoning processes that occupational therapists use may help frame how acute care occupational therapists navigate the discharge planning process.

Factors Considered by Therapists in Making Discharge Recommendations

There are many factors that need to be considered in making discharge recommendations, such as the patient's age, premorbid level of function, and results of outcomes measures (Stein et al., 2015). A large multinational study called the *ACMEplus* project examined factors that facilitated discharge planning and helped predict discharge destinations for elderly patients (Campbell et al., 2005). The researchers found there were

many factors that need to be taken into consideration when determining discharge disposition, however cognition and level of physical functioning were statistically significant as the best predictors of mortality, discharge disposition, and length of stay for older adult patients. A group of conditions that can contribute to a hospital admission that they termed *geriatric giants* (i.e., issues with falling, mobility, cognition, and bowel/bladder function) were also found to be stronger predictors of post-discharge institutionalization rather than age itself. However, each factor needed to be considered individually in terms of impact on discharge planning.

Jette et al. (2003) in their grounded theory study of the discharge decision making process of acute care occupational and physical therapists, found that when making discharge decisions therapists considered age, socioeconomic status, caregiver support, home situation, co-morbidities, issues with pain, prior level of function, and current level of function at discharge. In addition, they also considered issues of third party payers, health care and hospital rules and regulations, patient's ability to learn, level of motivation, and endurance as well as the physical, social, and attitudinal environments, and the client's wants and goals. The researchers also found that as opposed to physical therapy, occupational therapists relied more on cognitive function and ADLs than on mobility. Occupational therapists are more holistic in their approach as they also consider client factors of "values, beliefs and spirituality" (Holm & Mu, 2012, p. 220).

Robertson and Blaga (2013) in their survey study of assessments used by acute care occupational therapists, suggested that client safety and patient/family concerns should be front and center with any therapist decision making. Robertson and Blaga (2013) found that patient interviews were used by therapists to elicit information on

cognition, functional mobility, upper extremity function, leisure pursuits, and the home environment. In a study that explored the discharge planning process from the perspective of acute care physical therapists, participants felt that discharge planning was primarily guided by hospital policies, but that mobility, family support, and discharge destination were key consideration in discharge planning, followed by patient's cognitive function (Matmari et al., 2014). As in the other physical therapy studies reviewed in this chapter (Jette et al., 2003; Kasinskas et al., 2009; Masley et al., 2011), mobility was identified as the number one issue to consider with discharge planning.

Cognitive function. According to a survey study about assessments used by acute care occupational therapists, many therapists considered cognitive function an important predictor of patient safety (Robertson & Blaga, 2013). The researchers found that participants did not routinely use cognitive assessments, but rather gauged cognitive function and safety by observing patients engaged in functional activities as it reflected the patient's problem solving abilities. Of those participants in Robertson and Blaga's (2013) study who used standardized cognitive assessments, the most commonly used were "Cognistat, Rivermead, Lowenstien Occupational Therapy Cognitive Assessment (LOTCA), and the Mini Mental State Evaluation" (p. 131). When patients were deemed incompetent, families were then considered the *client* in the discharge decision-making process (Moats, 2007).

Optimal Discharge Planning

According to the Joint Commission (2012), for a successful transition in care, discharge planning should begin at the time of admission with a risk factor assessment completed within the first 24 to 48 hours, and follow-up contact with the patient within

24 to 48 hours of discharge. A discharge is deemed successful when there are no adverse events (i.e., unforeseen complications, illnesses, or injury), and the patient is able to progress towards his or her goals throughout the continuum of care (MLN, 2014).

With the continued interest and importance of discharge planning, several studies have examined what constitutes good discharge planning. Patient safety and inclusion of the patient in the process are considered two of the most important aspects of successful discharge planning (Robertson & Blaga, 2013). Optimal discharge planning is also when the patient is discharged safely to the correct setting with needed equipment and services put in place, and where hospital policies and processes do not dictate otherwise (Matmari et al., 2014). Successful discharge planning also includes taking a more holistic approach in determining readiness for discharge (i.e., not focusing solely on physical function), improving multidisciplinary coordination between hospital and community health care service providers, and additional staff training in discharge planning (Connolly et al., 2009).

Holm and Mu (2012) in their phenomenological study of experienced therapists and discharge planning with older patients, suggest the way to enhance discharge recommendations is by developing a more accurate and comprehensive occupational profile through the use of standardized and holistic assessments that explore cognitive function and the issues and needs from the client's perspective. Those involved in discharge planning need to anticipate patients' present and future needs (i.e., occupational performance issues) in order to make accurate recommendations for post discharge (Bowles et al., 2008; Connolly et al., 2009).

Perceived Barriers to Successful Discharge Planning

Most of the literature related to acute care discharge planning revolves around perceived barriers to comprehensive discharge planning, and the risks associated with poor discharge planning as they can result in poor outcomes and deleterious effects on patients' quality of life "at discharge and beyond" (Nosbusch et al., 2010, p. 771).

Transitions from hospital to home do not always go smoothly, as there can be many barriers to successful discharge planning.

According to a meta-review of discharge planning interventions, one of the barriers identified was patients being discharged with residual needs (Mistiaen et al., 2007). These included ADLs, instrumental activities of daily living (IADL), difficulty with medication compliance, having symptom distress, social and emotional problems, or other issues causing adverse events, and medical complications resulting in hospital readmissions. A questionnaire study that explored the discharge planning process from the perspective of acute care physical therapists also identified patient/family lack of awareness of the discharge process (e.g., unrealistic expectations), timing of consults, lack of communication and collaboration among team members, and organizational policies as barriers to successful discharge planning (Matmari et al., 2014). Other perceived barriers including lack of health care resources (e.g., lack of available rehabilitation beds and post discharge support), disagreement or conflict between the team's recommendations and the disposition the patient or family wants, discharge to less than effective or inappropriate settings, or inadequate resources or lack of patient/family skill to effectively advocate for needed resources.

In many cases, readmissions are preventable as they are due to premature hospital discharges to an inappropriate or less effective destination, or when there are inadequate post discharge supports put in place (Matmari et al., 2014; Wong et al., 2011). In reviewing the literature, other perceived barriers to discharge planning involve time constraints, short hospital stays, quick discharges, poor communication and collaboration among stakeholders, lack of patient and family input, underutilization of a client-centered practice approach, and constraints within the hospital environment itself which are discussed below.

Time Constraints

The new reality of practice for acute care occupational therapists involves working within the time constraints of a fast-paced environment (Craig et al., 2004). In a questionnaire study that explored the nature of acute care occupational therapy practice in New Zealand, 88% of respondents identified time constraints as a barrier to the provision of occupational therapy services and successful discharge planning. Time constraints generally reflect the limited patient/therapist interaction time, and limited time for patients to recover and rehabilitate due to short lengths of stay.

Time constraints were also expressed as limited time for staff to attend multidisciplinary team meetings, read documentation, or collaborate with others due to productivity and caseload pressures. For example, in a Delphi study to improve multidisciplinary discharge planning teams through consensus, Atwal and Caldwell (2003a) found that many team members did not participate in team meetings because of time constraints. In a related study, Atwal and Caldwell (2002) attempted to find ways to improve multidisciplinary discharge planning through the use of integrated care

pathways. Through audits of documentation and variances from pathway standards of care, they found that time constraints were identified as barriers to setting goals and accessing the pathways.

Nosbusch et al.'s (2010) nursing literature review of perceived barriers to discharge planning also found that time constraints, along with poor communication and uncoordinated care were contributors to poor discharge planning. As in Atwal and Caldwell's study (2003a), lack of time was identified as a barrier for nursing attendance at discharge planning team meetings. The nurses in the studies reviewed by Nosbusch et al. (2010) felt there was insufficient time for comprehensive discharge planning as patients' hospital stays were short with quick patient turnover. In a study of acute stroke patients and staff compliance with discharge guidelines by Luker and Grimmer-Somers (2009), they found that multidisciplinary teams' compliance with three established discharge planning guidelines—(a) team and patient/family meetings, (b) involvement of patient/carers in the development of a post-discharge plan, and (c) occupational therapy pre-discharge home assessment and equipment education—was inconsistent. The researchers concluded that non-compliance may have also been a factor of time constraints.

Short hospital stays. Time constraints in many instances are a result of short lengths of stay. Bauer, Fitzgerald, Haesler, and Manfrin (2009) conducted a literature review that examined best discharge planning practices in meeting the special needs of the frail elderly patient and their caregivers. They found that shortened hospital stays have resulted in patients being sicker at discharge with increased caregiver burden. This is an important issue because post-discharge care is increasingly being provided by

informal or family caregivers. Hospital stays are so short that patients are often asked to make decisions while they are still in a vulnerable position, or they are in no condition to participate in the discharge planning process (Connolly et al., 2009).

The trend for short hospital stays has even affected the amount of time that staff can spend on discharge planning. As a result, there is often not enough time for comprehensive and holistic discharge planning. This becomes evident when therapists have difficulty with discharge decision making, as they have not had enough time with the patient to do a proper assessment and to obtain all the information they need to make an appropriate discharge recommendation. For example, the “time available to practitioners to prepare patients for discharge...[has] virtually evaporated with [the] decreasing lengths of [hospital] stay[s]” (Maramba, Richards, Myers, & Larrabbe, 2004, p. 123). Limited therapist-patient time may also contribute to patient’s lack of understanding of occupational therapy services and resources (Brown et al., 2012), which may indirectly affect patients’ perceptions and willingness to accept occupational therapy discharge recommendations.

The trend for short hospital stays has also been identified as a constraint on acute care therapy discharge planning (Jette et al., 2003; Masley et al., 2011). In a grounded theory study exploring the role of acute care physical therapy, it was felt that short patient stays meant that patients had only limited time to work with physical therapists (Masley et al., 2011). Alternatively, the physical therapists felt challenged to make discharge decisions when they only had a limited amount of time to spend with their patients. Moats (2006) in her study of institutional factors that influenced discharge planning with older patients, found similar results for acute care occupational therapists, where

therapists felt pressured to make quick decisions based on limited time with patients. Jette et al. (2003) in a grounded theory study of the acute physical and occupational therapy discharge decision making processes, found that therapists often had to make discharge decisions upon their initial visit with patients. This added to the challenge as decisions needed to be made when not all pertinent information was yet known or made available to them.

Bowles et al. (2008) in their comparative case study of discharge recommendations for older patients, also found that time constraints and limited patient information complicates therapist discharge decision making, making the process more difficult and less accurate. For their study, the researchers recruited an outside group they felt were experts in discharge planning. This group consisted of four nationally known scholars and four hospital clinicians experienced in discharge planning. The researchers found that outside *experts* were more accurate in their discharge recommendations, as they did not have to make decisions within the same time constraints as hospital staff. The experts were 18 times more likely to recommend post-discharge services for patients than hospital clinicians. Bowles et al. (2008) also attributed challenges in discharge decision making to shortened hospital stays, inconsistent assessment standards, varying levels of risk tolerance, and staff experience. The results of their study indicated that participants felt discharge planning was disjointed as there was no standardization in terms of policies or protocols.

Short hospital stays, quick discharges, and the fast pace of the acute care environment has put a greater focus on discharge planning for acute care occupational therapists (Blaga & Robertson, 2008). Acute care practice can be constrained by quick

discharges, but also by economics and a medically oriented focus. In addition, short hospital stays have even raised questions about whether acute care therapy services are of benefit to patients (Masley et al., 2011). Hospital stays are so short, that it has been suggested that acute care may not be the correct setting for determining the long-term needs of patients (Brown et al., 2012; Craig et al., 2004; Luker & Grimmer-Somers, 2009; Moats, 2006; Mor & Besdine, 2011). Discharge planning in acute care cannot adequately predict patients' long-term needs, especially if there is a change in the patient's health or social circumstances (Luker & Grimmer-Somers, 2009).

Quick discharges. In relation to short lengths of stay, hospital staff often feel pressured to support quick discharges because of organizational financial issues for quick bed turnaround for new admissions. Several studies have found that staff felt pressured by their organizations to discharge patients quickly as soon as medical stability was achieved. This did not allow adequate time to make sure patients were safe or community services were in place, despite risks of readmission or the impact on patients (Connolly et al., 2009; Matmari et al., 2014; Mukotekwa & Carson, 2007; Wong et al., 2011). Quick discharges may also lead to consequences detrimental to patients' ultimate level of rehabilitation (Moats, 2006).

Quick discharges often do not give hospital staff enough time to prepare patients for discharge or ensure a seamless transition to the discharge disposition site, both which may contribute to patients being discharged with unmet needs (Connolly et al., 2009). In a study by Connolly et al. (2009) exploring health professionals' perceptions of the discharge planning process, hospital staff often felt frustrated and caught in the middle between their responsibilities to their patients, and the facility where they were employed.

However, the hospital staff wanted to do *a good job* for their patients despite feeling pressured to support quick discharges. Wong et al. (2011) in their study of health care providers' perceptions of the quality of the discharge planning process, also found that staff shortages, poor communication, and pressures to discharge patients prematurely resulted in poor discharge planning. However, the participants in Connolly et al.'s (2009) study found that quick discharges may not be all bad as they can also reduce patients' risk of contracting secondary complications (e.g., nosocomial infections). This is an important point as antibiotic resistant organisms, multidrug resistant organisms, and hospital superbugs are currently in the news and a concern for those who work in hospitals, but also the community at large.

Challenges of Client-Centered Practice

Some patients are discharged without their input or regardless of what is most important to them (Brown et al., 2012; Robertson & Finlay, 2007). Nonetheless, the client's wants and needs should be a central factor in discharge planning, and client-centered practice is one of the core competencies of worldwide occupational therapy practice (Falardeau & Durand, 2002; Maitra & Erway, 2006). Client centeredness also promotes greater patient involvement in the decision-making process (Atwal & Caldwell, 2003b). Unfortunately, many institutional environments have documentation and productivity standards that do not allow therapists the luxury of time to adequately address client centeredness (Moats, 2006; Moyers, 2004). This is despite support of client-centered practice from hospital accrediting agencies such as the Commission on Accreditation of Rehabilitation Facilities and the Joint Commission on Accreditation of Healthcare Organizations. These organizations recognize that client-centered practice

increases client satisfaction, decreases length of stay at rehabilitation centers, and improves functional outcomes.

In a study of British hospital teams, there was a lack of focus on clients in discharge planning as patients were rarely mentioned or involved in decisions (Pethybridge, 2004). Patient-centered discharge planning was viewed by members of the hospital team as stressful, causing delays in discharge, and bad for the hospital's bottom line. Discharge planning was also structured to be of more benefit to the organization, as quick patient turnover freed up more beds for new admissions. According to the findings of a nursing literature review on discharge planning of the frail elderly and their carers, few studies were found that included families and caregivers as part of discharge planning interventions (Bauer et al., 2009).

In a study by Moats (2007) that explored professional commitments of hospital-based occupational therapists to client centeredness and enabling occupation, discharge decision making was viewed as a straight-forward process except for patients that were not cognitively intact or required extensive assistance from others. Therapists were often unaware they may have used coercion and intimidation in persuading patients to agree to therapists' discharge recommendations. The researcher suggested that discharge planning be more client driven, with a negotiated approach that involved a balance of risk avoidance (i.e., safety) and autonomy for those who were more dependent or cognitively impaired (Moats, 2007). Another consideration is that involvement, participation, and patient centeredness can have different meanings and should be defined (Huby et al., 2007). For example, patients may want to be informed about their care, but not necessarily have a say in all care decisions (Huby et al., 2007).

There may also be differences in how client centeredness is perceived by the parties involved. In a survey study that compared the perceptions of clients and practitioners, differences were found in their experiences of client-centered practice (Maitra & Erway, 2006). For example, the majority of the therapists in this study felt they were client centered because they provided goal options to clients; however, the vast majority of patients indicated they were not involved in goal setting and were unfamiliar with the term *client-centered practice*. Hospital-based therapists also had the most difficulty in being client centered, which the researchers felt may have been explained by the unnaturalness of the setting. However, another explanation may have been the perceived passive role of the patient in the acute care setting.

According to several studies, hospital patients are often more passive by handing over control to staff and assuming the *sick role* (Maitra & Erway, 2006; Huby, Stewart, Tierney, & Rogers, 2004). In Huby et al.'s (2004) study of older patients they found that many of the patients did not take the initiative in contributing to discharge plans, perhaps because of failing health, a decline in cognition, or a loss in social standing. The older patients in this study often reported relinquishing health care decisions to younger members of their family as they did not feel competent in providing input. They also felt it was better to leave decisions in the hands of the experts, thereby adopting a passive role. This was validated in an ethnographic study by Huby et al. (2007) of older patients and their health care providers where passivity was found in patients who viewed health care providers as more competent because they were well educated and better informed. The researchers also found that among participants with increased frailty there was an

associated decrease in health-care decision making, further increasing dependence on others.

Older patients may also not want to be perceived as complainers or critical of staff, feeling they need to oblige staff out of respect for the staff's authority (Huby et al., 2004). Ironically, because the older patients in Huby et al.'s (2004) study did not want to *rock the boat* they did not participate in discharge decisions, but were then perceived by staff as not being competent or lacking in motivation. The researchers found it difficult to ascertain whether patients were truly unmotivated or lacked understanding of the process. In addition, input from older patients was not always solicited, as the health care providers did not trust the judgment of their patients preferring to err on the side of risk avoidance out of fear of litigation (Huby et al., 2004). The researchers found that what some health care providers perceived as patient lack of motivation, was more a reflection of the health care providers themselves not seeking out patient input or involving them in goal setting.

With a lack of input from patient and families, health care providers may not be aware of patients' wants and needs, which would be counter to client centeredness. Studies have shown that the relationship and communication between families and health care providers is often poor due to lack of information sharing, power differentials, and issues of control. Pethybridge (2004), in her study of factors that promote or inhibit multidisciplinary team discharge planning, found that normally patients were rarely mentioned although they are at the center of discharge planning. "It was disheartening that patients were not generally involved in decision-making for discharge planning, more often being informed of discharge dates and plans" (Pethybridge, 2004, p. 39). A

nursing literature review of studies examining perceived obstacles to comprehensive discharge planning provides further support, as in articles reviewed prior to 2000 patients and families were rarely involved in discharge decisions.

In a review of nursing literature on the discharge planning practices for frail elderly patients and their carers (Bauer et al., 2009), and an ethnographic study of elderly patients' participation in discharge planning (Huby et al., 2007), differences were noted in the perceptions of patient discharge needs between staff, patients, and family members. Patients were often excluded from the discharge planning process with a heavy reliance on formal assessment data and care routines that dehumanized patients as they focused on mental status and physical abilities (Huby et al., 2007).

Patients were dissatisfied and viewed discharge planning negatively when they felt they were uninformed and excluded from the process (Hager, 2010; Mukotekwa & Carson, 2007). Brown et al. (2012) explored elderly patients' perceptions of discharge in a hospital to home transition program called InReach. The participants felt discharge planning was haphazard and provoked feeling of anxiety, uncertainty, and disillusionment. Participants also expressed feelings of abandonment, as they were not informed about discharge related information or follow-up services, and at times felt they did not understand what was going on. The participants in Brown et al.'s (2012) study also felt disempowered as their input was not sought out when decisions were being made about them. For example, the patients did not know they were expected to receive occupational therapy, were not consulted about the occupational therapy referral, and although they had not been seen by occupational therapist in the hospital, an occupational therapist unexpectedly showed up at their home after discharge. However, there was a

general sentiment that patients wanted to feel listened to, informed, and included in the discharge process. Moreover, patients interacting with staff who had a helpful attitude and knowledge about the patients' medical history and personal information, inspired patients' confidence and trust. Participants felt this was more important to them than the therapist's qualifications. In addition, Brown et al. (2012) felt that better communication may lead to patients taking a more active role in their rehabilitation.

Barriers to successful discharge planning also include (a) difficulty with patient recall of discharge instructions, (b) patients with impaired cognition, (c) passive or unmotivated patients, (d) patients who are unable to articulate their concerns, (e) lack of available community services, and (f) family uncertainty about their abilities to assume the caregiver role (Hager, 2010; Maitra & Erway 2006). Other barriers to client centeredness can include (a) productivity pressures; (b) not having the time to involve patients in decisions; (c) working within an environment where there is poor communication between team members, and/or an environment that systematizes or dehumanizes patients, and (d) when patient's goals conflict with the health care team's agenda (Connolly et al., 2009; Maitra & Erway 2006).

Influences and Constraints of the Institutional Setting

The hierarchical medical model is often viewed as a barrier to client centeredness because it is a system where there are power differentials in which some voices carry more weight than others in discharge planning (Connolly et al., 2009). Within this system, health care workers may have a sense of deprofessionalisation as they conform to pressures outside their control. The locus of control in determining the final discharge

disposition in acute care traditionally lies with the physician, and not with other staff members including occupational therapists (Connolly et al., 2009; Moats, 2006).

Many times, staff members feel conflicted between organizational demands for efficiency and the complex needs of patients (Connolly et al., 2009). In a qualitative study by Moats (2006) exploring the institutional factors that influence discharge decision making of older patients from the perspectives of the occupational therapists, therapists' decisions were influenced by working within a medical model system. For example, participants felt pressured to make quick decisions supporting quick discharges that were not necessarily client centered, with a culture of "treat 'em and street 'em" (Moats, 2006, p. 111). In addition, different discharge settings other than home can be psychologically and emotionally momentous, especially to the older patient who wants to return to his or her own home but is no longer deemed safe or independent enough to do so.

Mukotekwa and Carson (2007) found organizationally that stakeholders (a mix of hospital staff including nursing, allied health professionals, social workers, and patients) were concerned about communication and documentation difficulties, time pressures on staff, delays in needed supports being put in place for discharge (e.g., home equipment), and policy changes where staff were uncertain about mandates of new government policies. Craig et al. (2004) surveyed New Zealand acute care occupational therapists and found that time management and practicing within time constraints is a reality of practice and was ranked as very high, while advocating for client interests was rated as very low, suggesting that practicing within the confines of the organization takes precedence over client-centered care. Similarly, in a study of health care professionals' perceptions of the

discharge planning process, participants viewed discharge planning as disjointed with no standardization in terms of policies or protocols, and that patients were prematurely discharged in order to free up beds for new admissions; thereby, benefitting the organization at the expense of patients (Wong et al., 2011).

Health care regulations and reimbursement policies. Health care organization regulations, policies, and reimbursement practices can have a profound impact on discharge planning.

The literature suggests that institutional policies and practices shape discharge decision-making processes by determining the length of stay and subsequently the time allocated to discharge planning, as well as the cost, nature and quantity of options for care upon discharge. (Durocher, 2014, p. 34)

In Jette et al.'s (2003) grounded theory study of acute care occupational and physical therapists they found that health care regulations were perceived as constraints because therapists often had to practice within a system that limited discharge options. These included the influence of different insurance coverage, pressure to reduce lengths of stay, and criteria for acceptance to an inpatient rehabilitation facility. For example, discharge recommendations are often constrained by the many limitations imposed by third party payers (Jette et al., 2003; Kasinskas et al., 2009). In Jette et al.'s (2003) study, although therapists' initial recommendations may have been based on what they believed was most appropriate for the patient, their recommendations were later modified once insurance coverage or lack of it was factored in.

Although options may be limited by reimbursement, where patients are discharged to matters. According to a prospective cohort study by Chan et al. (2013) of

patients with stroke, they found that patients with an inpatient rehabilitation facility stay had statistically significant higher scores on the Activity Measure for Post-Acute Care (AM-PAC) and more applied cognition and functional gains than the patients discharged to other settings, even controlling for age, therapy hours, co-morbidities, disease severity, and premorbid function.

In addition, therapists can feel pressured by administrators to meet government targets and productivity requirements, and demands of managers and government policies interferes with their roles as patient care providers (Connelly et al., 2009). Hospital-based health professionals in Connelly et al.'s (2009) study of the perceptions of discharge planning process, felt that some discharge procedures were dehumanizing to patients, as the hospital did not feel it was their responsibility to address any additional concerns once patients were medically stable.

Communication as a Barrier

Communication can be both a barrier and an effective tool in discharge planning practices. Concerns about communication between team members, stakeholders, providers, and patients and families were identified in virtually all research reviewed. Poor communication has associated with poor discharge planning contributing to poorer patient outcomes. In a qualitative nursing study of hospital staff and patient's views of the complexity of discharge planning practices, communication difficulties referred to difficulty reading notes in charts, delayed occupational and physical therapy consults, and problems with telecommunication systems (Mukotekwa & Carson, 2007). Documentation referred to poor notes, excessive paperwork, and duplication of information. Two nursing literature reviews also underscored the difficulty nurses found

in communicating between themselves, other disciplines, and with patients and families, including poor or incomplete documentation (Bauer et al., 2009; Nosbusch et al., 2010).

A lack of communication between team members can also keep some staff uninformed about patient progress, and add to the confusion with ordering tests or services (Connolly et al., 2009). Problems can also arise when there are disagreements about recommendations between team members and patients and families, and when patients have to be discharged to less effective settings (Matmari et al., 2014). Therefore, it is important to provide patients and caregivers with information and education about the patient's condition, prognosis, recognizing signs of complications, as well as physical, medication and nutritional care requirements (Bauer et al., 2009).

Elderly Patients

Although the elderly are not the focus of this study, they do have a prominent place in the discharge planning literature. Frail older patients often have co-morbidities in addition to the condition that necessitated a hospital admission, as well as associated issues of cognition and social emotional issues. As health care consumers, older adults often require a larger proportion of health care and community resources and greater support post-discharge (Holm & Mu, 2012). Increasingly, the complex care of the frail older patient becomes the responsibility of caregivers, so understanding and acknowledging the role of caregivers and including them in discharge planning is essential (Bauer et al., 2009). Discharge planning should not be based on ageism assumptions or intimidation, and should include the family as proxy decision makers when the patient lacks competency (Moats, 2007). New models should also be developed

that are geared towards meeting the needs of the acutely ill older patient (Hickman et al., 2007).

Risk and autonomy. Risk and autonomy appear to be prominent issues in discharge planning, especially for the older patient, and begs the question of what is considered an acceptable level of risk in terms of patient safety in setting the discharge disposition (Moats & Doble, 2006). There is a quandary for occupational therapists as they want to empower elderly patients to maintain their identity and self-worth, and want to respect patients' dignity and right to remain in the meaningful environment of their own homes, but therapists also want to do no harm if they judge the patient as unsafe (Moats & Doble, 2006). Making discharge recommendations is further complicated by patients with cognitive impairment, where the tendency is to be more paternalistic, solely focusing on risk avoidance and not patient autonomy (Moats & Doble, 2006).

What is most challenging is that risk is not a certainty of an adverse event but only a probability. With autonomy promotion, the discharge decision is client driven but may place the patient at increased risk of injury; thus, posing an ethical dilemma for the clinician. The essential goal for therapists is to ensure patient safety and minimize risk, but that can be both paternalistic and at odds with the older patient's wishes. For example, with risk avoidance the health professional makes discharge recommendations that are not necessarily client centered. Therapists may also unconsciously try to persuade or coerce patients into agreeing to their recommendations, because they believe they are acting in the patient's best interests (Moats & Doble, 2006). Unfortunately, this may unintentionally exclude patients and their families, or make them feel as if they are being left out of the decision making process.

Therapists' perception of risk is a key factor in discharge planning and is influenced by the therapist's experience and knowledge that things can go wrong (Atwal, McIntyre, & Wiggett, 2011). Risk assessment involves knowledge and management of perceived risks related to patient mental capacity, physical functioning and safety, and involves the therapist's level of risk acceptance or avoidance. In a qualitative study of acute care occupational and physical therapists' perceptions of older patients and risks associated with discharge, risk assessment was considered part of routine care, and some level of risk is necessary when patients participate in therapy (Atwal et al., 2011). They viewed acceptable risk as when the patient understood the risks involved, and unacceptable risk when the safety and well-being of the patient or others was put in jeopardy. Risk can also cause anxiety and uncertainty for therapists related to feelings of vulnerability and accountability because of the decisions and recommendations they make. However, risk sharing and risk management can be accomplished by consulting with other disciplines and using an interprofessional care pathway (Atwal et al., 2011). In an interesting note, Atwal et al. (2011) found that for some therapists who question the older patient's mental capacity, this may be in actuality a function of the therapist's level of discomfort. This illustrates how perceived risks and attitudes towards older adult patients can affect therapists' discharge recommendations.

A link was also found between patient participation and risk management systems in Huby et al.'s (2004) qualitative pilot study of older patient's participation in discharge decision making. The researchers found there was little open discussion of risk assessment, and current discharge planning systems discouraged input from patients as staff did not trust the older patients' competence to participate in the discharge decision

making process. Huby et al. (2004) speculated that there may be some unintended consequences or risks when patients are not part of the process, and when thinking about risk it has to be considered within context as it can be viewed differently by different parties. Concerns about risk avoidance and autonomy promotion do influence discharge planning for the older adult patient, as health care professionals are very aware of issues of accountability and liability (Huby et al., 2004; Moats & Doble, 2006). However, client-centered practice entails taking and accepting levels of risk, and teamwork and shared risk taking helps therapists with concerns about liability (Atwal et al., 2011).

It is important to look for ways to engage clients with impaired cognition in decision making based on their abilities, as competence should not be viewed as an *all or nothing* phenomenon (Moats & Doble, 2006). The challenge is finding ways to make negotiated discharge decisions based on partnership, mutual respect, and power sharing (Moats & Doble, 2006). In Moats and Doble's (2006) article on discharge planning with older patients they recommend advocating for patients in terms of health care and community resources, taking some professional risks, and allowing patients to take responsibility for risky decisions. They further recommend that providers and families not be held responsible if a patient's risky decision results in a negative outcome. However, they do suggest determining if patients are aware of risk levels, and that clinicians should seek out possibilities and opportunities for solutions where others may not (e.g., partial solutions, incremental coaxing and accommodation, and creative problem solving).

Ethical Dilemmas

In a study that explored the discharge planning process from the perspective of acute care physical therapists, the participants felt that ethical dilemmas are a common occurrence in discharge planning and acknowledged that there are some things outside physical therapy control, despite therapists' desire to always act in their patients' best interests (Matmari et al., 2014). Physical therapists may require not only expertise in discharge planning but also moral courage as there are both internal and external factors (e.g., laws, regulations, cost containment, and limitations imposed by third party payers) that constrain and influence discharge recommendations (Nalette, 2010). This sets up an ethical conflict as therapists want to meet patients' needs and uphold professional codes of ethics, but feel external factors negatively influence their clinical decisions.

Ethical conflicts are often framed as issues of safety (risk avoidance) and patient autonomy. Despite therapists wanting to be client centered, client-centered practice models are often unworkable and do not always translate into practice (Moats & Doble, 2006). Ethical conflicts can arise when therapists make recommendations that they feel are in a patient's best interests, but conflict with what the patient wants (Durocher & Gibson, 2010). For example, older adults prefer to be discharged back to their homes and communities, which are familiar and "enabling environments" (Durocher & Gibson, 2010, p. 2); however, this may not be the safest disposition. In this type of ethical dilemma, issues of safety often take precedence over issues of patient autonomy.

In a case study exploring the perceptions of elderly patients and acute care occupational therapy discharge planning and multidisciplinary teamwork, Atwal and Caldwell (2003b) found that occupational therapists often unintentionally violated the

four bio-ethical principles of autonomy, beneficence, nonmaleficence, and justice. For example, autonomy was violated when the patient felt disregarded by the therapist who performed a home visit. Beneficence was violated with the unnecessarily prolonged hospitalization and delayed discharge of a patient waiting for the arrival of an inappropriate hoist lift ordered by an inexperienced occupational therapist.

Nonmaleficence can occur when therapists do not speak up for what they believe to be the correct disposition for a patient and an inappropriate discharge plan is put into place. A participant in this study felt that when she did speak up, the physicians did not listen to her concerns. There was also the suggestion that therapists' recommendations were not solicited as occupational therapy was perceived as delaying discharge. Violations of justice were described as putting the needs of the organization before patients' needs, through quick discharges and "cutting corners" (Atwal & Caldwell, 2003b, p. 249). Poor client outcomes and therapist burnout may also be a consequence of unsuccessful management of ethical issues (Atwal & Caldwell, 2003b).

There is also only limited literature available to assist therapists in ethical decision making with difficult and complex discharges (Durocher & Gibson, 2010). Ethical practice demands that patients' values and choices be respected even if that conflicts with the health care team's beliefs in what is in their patients' best interests (Durocher & Gibson, 2010). It is also an ethical imperative to increase understanding from the patients' perspective and their meaningful involvement in the discharge decision making process (Huby et al., 2007). It is recommended that health care providers communicate with patients to determine levels of acceptable risk and identify methods to minimize risk

(Durocher & Gibson, 2010), and therapists should find ways to ensure that bioethical principles are always upheld in practice (Atwal & Caldwell, 2003b).

Discharge with Unmet Needs

It seems intuitive that having supports in place to meet patients' post discharge needs should result in reduced readmissions and risk of adverse events, and are therefore important for effective discharge planning. However, it is often difficult to determine and predict what patients' needs will be within the time constraints of the acute care setting. Several studies found that a percentage of patients are discharged with unmet needs (Duxbury et al., 2012; Luker & Grimmer-Somers, 2009; Mistiaen et al., 2007). In a meta-review by Mistiaen et al. (2007), these needs include continued assistance for ADLs, medication compliance, social and emotional problems, and ignorance of available community resources. In Duxbury et al.'s (2012) study of stroke patients discharged with unmet needs, areas that were identified included ADLs, leisure, adaptive equipment, and return to previous social roles. Any one of these areas can be contributors to poor patient outcomes, adverse events, or a hospital readmission.

In a study of allied health staff compliance with discharge guidelines for acute stroke patients, they found a 40% shortfall between predicted or recommended community supports, and the discharged patients' actual needs (Luker & Grimmer-Somers, 2009). Shortfalls were determined by comparing post-discharge supports that were arranged, and the supports that patients actually needed. For one-third of the patients, supports put in place were inadequate as their needs increased instead of decreased over time. Patients felt that many of their difficulties post-discharge could have been predicted pre-discharge.

In a study of stroke patients discharged from acute care with unmet needs, approximately 13% of patients reported they were discharged needing occupational therapy but did not receive it (Duxbury et al., 2012). Those who reported having unmet occupational therapy needs had greater difficulty with ADLs prior to their stroke, a more acute presentation with lower Functional Independence Measure (FIM) scores, and greater dependence in ADLs than the other groups in the study. The researchers speculated that perhaps for those patients who required assistance with ADLs prior to and post stroke, their therapists may have had fewer expectations of their recovery and rehabilitation potential, so services were shifted to those who were less dependent with higher FIM scores (Duxbury et al., 2012).

In a study of staff compliance with national discharge guidelines for acute stroke patients, despite inconsistencies with adherence to the guidelines even when they were implemented, some patients were still being discharged with unmet needs (Luker & Grimmer-Somers, 2009). The researchers felt this may have been a factor of the established guidelines inaccurately reflecting patients' needs. For example, in a qualitative study of hospital staff's perceptions of the discharge planning process, researchers found patients were also admitted with complex psychosocial issues and complex living situations (i.e., homeless, abused, and terminally ill; Connolly et al., 2009). However, once these patients were medically stable they were discharged, still having many unmet social needs and with no intermediate plan in place to provide continued care. The health care providers in a study that examined their perceptions of the discharge planning process also felt patient psychosocial needs were inadequately addressed within the hospital setting (Wong et al., 2011).

Although it was felt that a predischARGE home visit in Luker and Grimmer-Somer's (2009) study of staff compliance with discharge guidelines would allow therapists to better anticipate patients' post discharge needs, statistically it did not seem to have an effect. This was despite the trend for patients with a predischARGE home visit being more than five times more likely to avoid discharge with unmet needs, in comparison to those patients who did not have a predischARGE home visit.

Discharge planning is a complex process and it is uncertain whether it is the nature of discharge protocols and staff compliance, the critical reasoning skills of therapists to predict discharge needs, availability of health care resources, family and community support systems, health care policies and regulations, the nature of the patients themselves, or a combination of factors that contributes to patients being discharged with unmet needs. Based on their meta-review of discharge planning interventions, Mistiaen et al. (2007) recommend that health care professionals continue to look for ways to prevent patients being discharged with unmet needs.

Even with the best of intentions, therapists' recommendations may fall short of patients' actual needs, their level of compliance, level of satisfaction, or what kinds of services will be available and accessible to patients after discharge. Patients themselves often do not realize what they will need or how their new limitations will impact them until they are settled back in their own homes (Duxbury et al., 2012). Health care providers also need to be able to differentiate between patient expressed needs and therapist assumed needs, as they may not be the same (Duxbury et al., 2012). It has been suggested that better communication and coordination between hospital and community providers can help bridge the gap so that if patients are discharged with unmet needs,

they can still receive the services and supports they need once back in the community (Duxbury et al., 2012).

Therapist Perceptions of Discharge Planning

Aspects of the client and institution are factored into the discharge planning process, along with the knowledge and skill of the therapist; however, how therapists perceive the discharge process may help us better understand what guides their discharge decision making. Therapists often feel pulled from both ends between wanting to be patient focused and the reality of working within the acute care system (Moats, 2006). For example, acute care occupational therapists can feel conflicted between being holistic and working in a reductionist medical model environment with its focus on pathology and physiologic function. Robertson and Finlay (2007) in their phenomenological study of the lived experience and meaning of practice for acute care occupational therapists, found that participants often felt powerless working in a system where the focus was not on reducing dysfunction and promoting independence, but rather on quick discharges.

Even though occupational therapists recognize that rehabilitation can rarely be completed during a hospital stay, practicing in these conditions can leave them feeling unsatisfied and disappointed in their contributions towards patient care (Blaug & Robertson, 2008). Robertson and Finlay (2007) found that therapists wanted to make a difference for their patients but could not always provide the care that they wanted to. “Uneasy feelings were experienced by those occupational therapists who had to make pragmatic decisions to adopt a procedure-centred rather than patient-centred approach in order to cope with their workload, at the cost of not meeting their holistic ideals” (Robertson & Finlay, 2007, p. 75). Therapists felt they were expected to see too many

patients in too short a period of time so that the services they provided were ineffective and not client centered (Robertson & Finlay, 2007).

Occupational therapists are also excited, gratified, and fulfilled by the services they perform in helping their patients (Robertson & Finlay, 2007). The participants in Matmari et al.'s (2014) study of acute care physical therapy perceptions of the discharge planning process felt supported as the team's selected discharge disposition was generally in agreement with physical therapy recommendations. As in Robertson and Finlay's (2007) study, Matmari et al. (2014) also found that therapists felt they did not have enough time to work with their patients but took pride in the services they were able to provide.

Occupational therapists also felt appreciated and supported when other team members recognized occupational therapists' input and their role in discharge planning (Robertson & Finlay, 2007). However, when occupational therapy recommendations were not acknowledged, the occupational therapists felt worthless and misunderstood. Similarly, in a study that explored the nature of acute care occupational therapy practice in New Zealand, the participants also expressed frustration that occupational therapy was often misunderstood, occupational therapy services were undervalued, and only limited respect was afforded to occupational therapy (Craig et al., 2004). For example, participants felt that patients were frequently discharged with little to no occupational therapy input. An occupational therapy participant in an ethnographic study of elderly patients and their health care providers also commented that she felt excluded from the discharge planning process as there was a reliance on physical therapy evaluation for input on disposition but not occupational therapy (Huby et al., 2007). Exclusion from

discharge planning is not just specific to occupational therapy as Nosbusch et al. (2010) found a lack of visibility of nursing input in the discharge planning process.

Despite having worked with occupational therapists, some patients remain uncertain about the profession, tending to confuse occupational therapy with physical therapy (Brown et al., 2012). Perhaps this can be partially explained by the results of a study about perceptions of client centeredness among occupational therapists and their clients in which 40% of the participants felt that occupational therapists did not explain what their service was about or how it could benefit them as patients (Maitra & Erway, 2006). The participants in Masley et al.'s (2011) grounded theory study also felt that the role of physical therapy in acute care was also largely misunderstood and may have been underutilized. Similar to the findings in Robertson and Finlay's (2007) study, the physical therapists in Matmari et al.'s (2014) study found that they felt disrespected when their physical therapy recommendations were not followed. In addition, physical therapy participants felt they were involved in team discharge planning but had no say in terms of discharge date as that was determined by hospital policy regardless of physical therapists' perception of patient readiness for discharge.

Strategies and Recommendations for Comprehensive Discharge Planning

Several strategies for successful discharge planning that may also help counter barriers to discharge planning were found in the literature and included (a) use of standardized and predictive assessment and screening tools (Boronowski et al., 2012; Jette et al., 2014; Stein et al., 2015); (b) multidisciplinary teamwork (Atwal & Caldwell, 2003a; Pethybridge, 2004), (c) good communication with all stakeholders (Crennan & MacRae, 2010; Pethyridge, 2004); (d) coordinated care among team members and

community providers (Luker & Grimmer-Somers, 2009); (e) inclusion of patients and families in goal setting and the discharge planning process (Bauer et al., 2009; Crennan & MacRae, 2010; Duxbury et al., 2012; Luker & Grimmer-Somers, 2009; Pethybridge, 2004), and (f) individualized discharge plans that focus on patient satisfaction and prevention of adverse events post discharge (Shepperd et al., 2013). There is also evidence to support intensive discharge preparedness programs (Hager, 2010), and comprehensive discharge planning as a means to reduce readmissions and improve patient outcomes (Hickman et al., 2007). Methods to improve discharge planning practices are of interest to all stakeholders as ineffective discharge planning can result in increased readmissions and decreased patient quality of life (Mukotekwa & Carson, 2007).

Assessment and Screening Tools

The purpose of discharge planning is not just about preparing the patient to leave, but also assessing whether they will be able to function once they leave the hospital setting (Matmari et al., 2014). Discharge planning usually begins on the day of admission (Matmari et al., 2014). For most therapists the assessment process begins from the moment the therapist enters the patient's room with the interview being the most commonly used assessment tool (Robertson & Blaga, 2013). Despite this informal approach, the potential of using standardized assessments as tools to help therapists make accurate discharge recommendations has been a topic of interest over the years. Many believe using standardized assessments would increase the accuracy of predicting patient post-discharge needs, and allow therapists to better communicate their findings and opinions to other stakeholders (Robertson & Blaga, 2013).

There are several mathematical models that show the relationship between factors and selected discharge disposition, but these may be too generic and not of much benefit as they are not individualized enough to the specific patient, despite their ability to reduce some of the uncertainty in discharge planning (Jette et al., 2003). According to a study by Bland et al. (2014), using standardized assessment scores from occupational and physical therapy initial evaluations of stroke patients can be helpful in discharge planning, but also somewhat limited in guiding clinicians' discharge recommendations. The researchers also felt that some clinicians may find it difficult to see the connection between discharge recommendations and final outcomes as most clinicians do not see their patients after discharge.

In addition, there is no one standardized discharge assessment tool currently available that is comprehensive, individualized, or inclusive enough for the diversity of patients seen in the acute care setting (Boronowski et al., 2012; Crennan & MacRae, 2010). Robertson and Blaga (2013), in the review for their survey study about assessments used by acute care occupational therapists, did not find any evidence of use of standardized assessments in acute care practice with the exception of one study that referenced the use of the Kohman Evaluation of Living Skills (Crennan & MacRae, 2010), which was used to confirm therapists' observations. In addition, there are no clear guidelines for determining rehabilitation needs or disposition, so there is variability in the level of patient care and quality of the rehabilitation needs assessment process (Stein et al., 2015).

Despite interest in using standardized assessments, acute care therapists rarely use them preferring to rely on patient interviews and observation of functional activities

(Blaga & Robertson, 2008; Crennan & MacRae, 2010; Jette et al., 2003; Jette et al., 2014; Robertson & Blaga, 2013; Matmari et al., 2014). For example, in an ethnographic study of acute-care occupational therapists' critical reasoning and use of discharge assessments for elderly hospital patients, only 30% of experienced therapists used standardized assessments (Crennan & MacRae, 2010). However, the majority of participants relied on their critical reasoning skills of patient related factors and observation of functional performance (Crennan & MacRae, 2010). In a pilot study exploring the use of a standardized assessment in helping to predict rehabilitation needs and referrals for acute stroke patients, the researchers found that decisions to recommend an acute inpatient rehabilitation stay versus a skilled nursing facility was influenced by the clinical presentation and other patient related factors, or by non-clinical considerations such as cost or bed availability (Stein et al., 2015).

Two studies of New Zealand acute care occupational therapists found that the majority of participants only used standardized assessments when there was suspicion of cognitive impairment (Blaga & Robertson, 2008; Robertson & Blaga, 2013). However, Robertson and Blaga (2013) did find that the Westmead Post Traumatic Amnesia Scale, the Canadian Occupational Performance Measure, the Barthel ADL Index, the Functional Independence Measure, and the Assessment of Motor and Process Skills were occasionally used by participants in their study. It has been suggested that standardized assessments are rarely used by therapists in acute care because they are more time consuming and stressful in terms of productivity than informal assessment methods, or because therapists are simply unfamiliar with standardized assessments that would be

compatible within the acute care setting (Jette et al., 2014; Robertson & Blaga, 2013; Welch & Forster, 2003).

Even though standardized assessments are rarely used, participants in a study of acute care physical therapy discharge planning felt that standardized assessments should be used as an objective measure on which to provide evidence for therapists' discharge recommendations (Matmari et al., 2014). In a large retrospective study of occupational and physical therapists' use of assessments in predicting discharge placement, their findings suggest that using standardized assessments can be a very valuable tool in predicting discharge disposition (Jette et al., 2014). For example, the Boston University's AM-PAC assessment is a quick and easy tool that can help with predicting discharge disposition (Jette et al., 2014), as well as being G-code compatible. In another study on the use of standardized assessments in predicting rehabilitation needs of acute stroke patients, the researchers found that ADLs assessments were helpful in predicting home versus inpatient rehabilitation placement (Stein et al., 2015). Statistical significance was attained with higher Barthel Index scores being associated with discharge home rather than an inpatient rehabilitation, and older patients or those with a premorbid disability being less likely to be discharged to an acute inpatient rehabilitation facility (Stein et al., 2015).

Chang, Ni, and Jette's (2014) correlational study took a different approach in that they wanted to explore whether the level of the International Classification of Functioning, Disability and Health (ICF) system's activity limitations could help predict discharge disposition with the AM-PAC as the primary outcome measurement. The researchers found that diagnosis (i.e., neurologic conditions, lower extremity orthopedic

trauma, and complex medical conditions) was not a strong predictor of discharge destination but activity and functional performance limitations were—primarily limitations in mobility. For example, a statistically significant association was found between AM-PAC basic mobility scores and a discharge home, indicating that patients with good mobility were more likely to be discharged home. Based on their findings, the researchers suggest that basic mobility is a stronger predictor of discharge disposition than level of daily activity functioning. In another example, the Occupational Therapy Discharge Needs Screen (OTDNS) was recommended as a screening tool to help identify patients with complex needs who may benefit from a full assessment, additional resources, or were at risk of poor rehabilitation outcomes (Boronowski et al., 2012). Though, the OTDNS was mostly used to indicate whether there was a need for an occupational therapy home visit within the Canadian health care system, which is different than in the United States.

Although standardized assessments can help determine level of performance and predict post discharge needs, they are also helpful in communicating with other stakeholders and can provide credibility for occupational therapy recommendations. However, there is also the risk that there is too much emphasis on patient cognitive and physical performance scores, so that the patient’s viewpoint is filtered out of the assessment process (Robertson & Blaga, 2013). Another concern with using standardized assessments is that there may be some embedded assumptions “about the ‘usual’ problems and...the ‘findings’ are shaped by the questions” (Robertson & Blaga, 2013, p. 133).

Much of the acute care literature from United Kingdom, New Zealand, and Australia references the assistance of predischARGE home visits in determining patient safety to return home, but there is some controversy over the effectiveness of this approach (Robertson & Blaga, 2013). In any case, predischARGE home visits are not part of routine dischARGE planning practices in the United States.

DischARGE Interventions

DischARGE interventions are viewed as methods to improve dischARGE planning and to ensure a smoother transition from hospital to home. Hager (2010) undertook a quasi-experimental study to examine whether an added nursing dischARGE intervention program would result in improved and more comprehensive dischARGE planning. The study sample included 26 medical-surgical and hospice patients from a subacute urban hospital, who were divided into a control and experimental groups. The added intervention program consisted of early and intensive dischARGE rounds, early identification of patient perceived dischARGE goals and barriers to dischARGE, an individualized plan of care, medication education, nutritional counselling, written treatment goals, and the tentative dischARGE date posted in the patient's room. Patients were further provided with a comprehensive dischARGE planning brochure, access to a video about the dischARGE process developed by the researcher, a form where patients could track their progress, and a list of the hospital library's patient education materials specific to the patient's medical condition.

The researcher found that those with the added dischARGE intervention program felt better prepared for dischARGE and managing their medical condition, and had better awareness of their post-dischARGE treatment plan including medical follow up and available community services. For the intervention group, there were also no reports of

adverse events or readmission within two weeks post discharge. Hager's (2010) study provides evidence for the incorporation of this type of early and intensive interdisciplinary discharge planning intervention. According to Hager, this study also supports the literature (Jack et al., 2009; Naylor et al., 1999; Weiss et al., 2007) that high-quality discharge education is associated with more positive perceptions of discharge readiness and reduced risk of readmission and adverse events.

An updated Cochrane Database of Systemic Reviews article titled "Discharge Planning From Hospital to Home," examined the benefits of individualized versus routine discharge planning (Shepperd et al., 2013). The review generally described what was included in intervention programs, but did not define what constitutes individualized discharge planning. However, the review did provide evidence to support an individualized discharge plan approach, which was associated with shorter hospital stays, reduced readmission rates, and increased patient satisfaction, but they did not find it had a significant effect on mortality or health care costs. Bauer et al. (2009) in their nursing literature review of discharge planning practices and experiences of frail elderly patients and their carers, found that the impact of discharge interventions on patient outcomes was inconclusive. Nonetheless, they did find evidence to support the inclusion of a liaison person or discharge coordinator, who could act as a central organizing and resource person in discharge planning and as someone who could help bridge pre and post-discharge care.

Mistiaen et al. (2007) took a different approach in that they undertook a meta-review of the literature on discharge planning interventions with the aim of identifying which interventions were most effective in preventing or decreasing the risk of post

discharge problems. They looked at two different groups of studies of discharge interventions, those that focused on discharge preparedness (i.e., to minimize need for post discharge assistance or unmet needs), and studies that focused on discharge support and aftercare. This second group of studies included interventions implemented after discharge to prevent readmissions and maximize the patient's functional, emotional, social, and physical health once back in the community. They found some evidence to suggest that educational interventions had a positive effect on emotional status, but they did not find evidence that discharge planning interventions improved the discharge process, post discharge function, or resulted in reduced health care costs. They speculated that timing may have been a variable, in that interventions may have needed more time for their impact to become apparent, or that the effects of the interventions did not have long standing effects and were no longer measureable.

Brown et al. (2012) examined a discharge intervention hospital to home program called Inreach, which may not be feasible in the United States as it involved having the same therapist work with the patient both in the hospital and once back in the community. This discharge intervention has the potential to promote seamless continuity of care and reduce risk of readmission as the therapist has a better understanding of the patient's needs and level of functioning both in the hospital and back at home, important aspects of effective discharge planning (Brown et al., 2012).

Patient preparedness. The aim of many discharge interventions is to better prepare patients for the transition from the hospital to home. A quasi-experimental and grounded theory study examined the inclusion of a patient-centered checklist in addition to standard discharge practices, as the researchers believed that increased patient and

family input would provide for a smoother transition hospital to home (Grimmer et al., 2006). This checklist covered items such as how patients' felt about safely leaving the hospital and arrival home, issues about isolation, caring for others and pets, knowledge and understanding about medications, equipment needs, home safety, leisure activities, homemaking, driving and transportation. The checklist was called PREPARED which stood for Prescriptions, Ready to Enter Community, Education, Placement, Assurance of Safety, Realistic Expectations, Empowerment, and Directed to Appropriate Services (Grimmer et al., 2006). The researchers found the checklist helpful in terms of patient preparedness, but only for those patients who had a support system available (i.e., involvement of friends and family) at home. For example, there was a stronger association between the use of the checklist and preparation for discharge for those subjects with a carer, as compared to the rest of the subjects in the sample. The researchers felt that due to the shortness of hospital lengths of stay, premorbid poor states of health, and especially for those who were alone, the checklist was not as beneficial as it could have been, but may have been helpful in heading off some post-discharge problems.

Crum (2011) was also interested in improving patient preparedness through the discharge intervention of an additional IADL program for surgical orthopedic patients (total hip or knee replacement surgeries). Crum found that the additional IADL intervention helped subjects feel more prepared for completing IADL (i.e., laundry, cooking, pet care, cleaning, and shopping), but in terms of feeling *prepared* or *very prepared* for discharge from the acute care setting, approximately the same percentage of subjects in both groups (control group 64% and the IADL intervention group 67%)

reported feeling prepared or very prepared for discharge. Studies and reviews by Brown et al. (2012), Crum (2011), Grimmer et al. (2006), Hager (2010), Mistiaen et al. (2007), and Shepperd et al. (2013) demonstrated that there is no one proven discharge intervention or approach that promises a smooth and comprehensive discharge from the hospital.

Multidisciplinary teamwork. Most of the studies reviewed listed multidisciplinary cooperation and communication as an important component of effective discharge planning (Atwal & Caldwell, 2003a; Luker & Grimmer-Somers, 2009; Pethybridge, 2004). Good teamwork involves consensus, trust, having a culture of learning, good leadership, and sharing of information and resources (Pethybridge, 2004). Successful discharge planning also requires a well-coordinated interdisciplinary team approach with an awareness of each discipline's area of expertise, and combining skills so that the team acts as an integrated whole by pooling resources and sharing responsibilities in working towards successful patient outcomes (Pethybridge, 2004). Atwal and Caldwell (2003a) in their Delphi study of multi-professional team discharge planning, suggested that team members should meet on a daily basis to discuss discharges and referrals. Wong et al. (2011) in their study of hospital health care providers' perceptions of the quality of the discharge planning process, also advocated having a multidisciplinary approach where each team member understood the role of the other professions as part of their recommendations for effective discharge planning. This was in addition to educating physicians on psychosocial factors, and having support systems in place for patients who require constant supervision or assistance. However, Pethybridge (2004) in her grounded theory study of multidisciplinary team discharge

planning found there were few resources devoted to improving multidisciplinary teamwork, communication, or leadership.

Effective communication as a tool in discharge planning. Effective communication is important and needed for a positive working environment (Craig et al., 2004). In a nursing literature review of evidence based interventions for elderly patients in the acute care setting, researchers found evidence that effective communication and comprehensive discharge planning resulted in positive patient outcomes, and showed promise for shortening hospital stays and reducing readmission rates (Hickman et al., 2007). Another nursing literature review of perceived barriers to discharge planning also found that improved communication between staff and post-discharge agencies, and increased collaboration and coordination between all team members should be part of discharge planning best practice (Nosbusch et al., 2010).

Additional studies support the importance of having a high level of interprofessional collaboration, information sharing, and communication between not only team members but also with patients and families including making sure they receive the necessary education for preparedness and an understanding of the discharge process (Bauer et al., 2009; Matmari et al., 2014). Multidisciplinary teams should also communicate with patients and families to discuss discharge planning, and involve them in planning for community support after discharge (Luker & Grimmer-Somers, 2009). In addition, strategies need to be put in place to improve communication between all parties (Bauer et al., 2009), and an environment should be set up that builds trust between all stakeholders (Huby et al., 2004).

Documentation. Documentation has also been included in the literature as a means of communication that can contribute to smooth and coordinated discharge planning. Several studies support the use of interdisciplinary documentation, simplifying documentation, incorporating screening tools into electronic documentation, or improving documentation skills (Atwal & Caldwell, 2003a; Connolly et al., 2009; Pethybridge, 2004; Wong et al., 2011). However, not all professions are in agreement with having interprofessional documentation (e.g., integrated clinical care pathways; Atwal & Caldwell, 2002). For example, in an action research study using integrated care pathways a participant occupational therapist in this study felt that occupational therapists should continue with their own documentation in order to preserve and maintain their professional identity (Atwal & Caldwell, 2002). In addition, the researchers felt that using this type of documentation could result in a decrease in face-to-face communication between team members. In a Delphi study of multi-professional team discharge planning, designating one person to document the patient's social history and functional level within two days of admission was considered a reasonable and desirable strategy for improving discharge planning.

Nosbusch et al. (2010) in their integrative review of nursing literature and perceived barriers to discharge planning, recommended the use of discharge checklists and clinical pathways as tools to improve discharge planning. However, in a study by Atwal and Caldwell (2002), multidisciplinary integrated pathways did not result in improved patient care, was an added burden in terms of time, and could potentially reduce direct interaction among staff. The only improvement noted was for the organization, and not interprofessional collaboration or communication.

Inclusion of patients and families. Several studies recommended more transparent discharge planning, improved patient and lay carers' understanding of the process, and inclusion of patients and families in the discharge planning process as methods to narrow differences in perceptions between patients/families and staff; thereby, fostering better feelings of trust (Bauer et al., 2009; Huby et al., 2004). In addition, understanding the perceptions of patients and seeking their input may be changing with the current emphasis on patient-centered care (Nosbusch et al., 2010).

Hospital staff need to put more trust in their patients' competence and encourage them to participate in the process; otherwise, discharge planning is based only on a one-dimensional view (Huby et al., 2004). In addition, therapists should advocate for increased patient education on use of assistive devices, community resources, and fall prevention (Duxbury et al., 2012). Educators can also do more to promote patient-centered, interdisciplinary, collaborative discharge planning and transitions in care including use of technologies like telehealth (Nosbusch et al., 2010).

Models. Various researchers have also recommended using different approaches or models to promote successful discharge planning. For example, Wong et al. (2011) in their study of health care providers' perceptions of the quality of the discharge planning process, recommended a shift from a disease management model to a more communicative and ethical quality of life focused approach. Mukotekwa and Carson (2007) in their study of the complexity of nursing discharge planning practices, developed a conceptual model that focused on cultural, organizational, and technological perspectives, and key areas for improvement identified by stakeholders. These included a need for more seamless care, a more holistic approach by nursing with greater utilization

of nursing staff, incorporation of information technologies to improve overall communication, and better utilization of resources for effective and efficient patient discharges.

Wong et al. (2011) also cited the model used in the United Kingdom where discharge planning is grouped into simple or complex discharges with 80% being simple. Wong et al. (2011) suggests that categorizing discharges may be an effective strategy in identifying high risk patients or complex discharges. Hickman et al. (2007) in their nursing literature review of evidence based interventions for elderly patients, concluded that new models need to be generated that are geared towards meeting the specific needs of the acutely ill older patient.

There is a correlation between the quality of discharge planning and readmission rates, offering further support for engaging in discharge planning best practices (Bauer et al., 2009), as readmission rates are a common barometer of successful discharge planning. The aim of acute care occupational therapy discharge planning is to address barriers to independent occupational performance in the area of self-care, and to ensure a safe discharge (Robertson & Blaga, 2013).

Schell's Ecological Model of Professional Reasoning

Ecology refers to the transactive relationship between the person and his or her various contexts, and is compatible with general systems theory, situated cognition, and pragmatic reasoning (Whaley, 2007). In an ecological approach, context includes the physical, temporal, social, cultural, and even institutional, economic, and political environments. Context and the environment are important factors in clinical decision making as they can either facilitate or constrain occupational performance (Chapparo &

Ranka, 2000). Having an understanding of an ecological approach can shift attitudes from patient-centered practice to a more holistic patient-environment centered practice model (Huynh & Alderson, 2009).

Schell's ecological model of professional reasoning is an ecological model that deals with the task performance of critical reasoning and clinical decision making. It was first introduced at the World Federation of Occupational Therapy conference in 2006. It has built on and been influenced by previous studies of occupational therapy professional reasoning processes including Tornebohm, the ecology of human performance, situated cognition, communities of practice, and critical reasoning approaches most notably by Mattingly and Fleming, and Schell and Cervero, among others (Schell et al., 2008).

There have been many studies of occupational therapy professional and critical reasoning approaches (Mattingly & Fleming, 1994; Schell & Cervero, 1993; Schell et al., 2008; Unsworth, 2012). These reasoning approaches, rarely used in isolation, are frequently combined based on what is needed for the specific therapy situation, or in response to problems that arise between the interface of the therapist, client, and/or practice contexts.

“Professional reasoning is a form of situated cognition that is shaped by the various communities in which one practices” (Schell et al., 2008, p. 421). Community of practice refers to the model created by Wenger and Lave (Wenger, 1998) that uses concepts of practice, identity, community, and meaning in understanding and facilitating knowledge acquisition, cohesion, and social learning. It is a form of collective learning formed by a group that share similar concerns and a mutual interest in sharing information and resources in order to solve a problem. According to Schell et al. (2008),

Schell's ecological model of professional reasoning sets up a community of practice of clients and therapists who through a collaborative relationship have a shared understanding that directs the "nature, scope, and trajectory of the therapy process" (p. 420). Schell's model and action research seem well suited to the community of practice of acute care occupational therapists who must consider multiple factors in making client-centered discharge recommendations. In addition, Schell's model is compatible with Jette et al.'s (2003) study that found acute care therapists' discharge decision making is a process that involves having information filtered through the therapist's lens of their experience and adjusted by knowledge of health care regulations and policies, with input from other team members.

Schell's ecological model of professional reasoning proposes that the reasoning process is directly linked to therapy action through the interface of the clinician, client, and practice context (Schell et al., 2008; Unsworth, 2012). According to Schell (2014), with an ecological orientation the professional reasoning of the health care provider is guided by his or her personal and professional viewpoints. Personal viewpoints or perspectives refer to the embodied characteristics of the provider, while professional perspectives are his or her worldview. Within the therapist's inescapable *personal lens* are characteristics that include the therapist's physical capacity, sensory profile, personality, intelligence, and sociocultural values, preferences, beliefs, and life experiences that make up the therapist's unique profile (Schell et al., 2008; Unsworth, 2012).

According to Chaffey (2009) this model essentially recognizes that reasoning processes are affected by the professional's personal history and experience, informs their

values, beliefs, assumptions, and views of their world, and which in turn influences how they choose to use knowledge and practice. Values, and beliefs of the professional body that the health care provider belongs to, in turn influences his or her personal lens. Within the health care professional's *professional lens* are practice theories, therapist knowledge, therapy beliefs, professional background, education, previous experience with other clients, skills, and technical and professional skills and routines (Chaffey, 2009; Schell, 2014). Together the therapist's personal lens and professional lens, "frames the therapy encounter" (Schell et al., 2008, p. 420) and guides how therapist's approaches the therapy situation in addressing clinical problems within the practice context. For example, the personal and professional viewpoints shape how the provider perceives and interprets their experiences, forming the lens through which therapy interactions are viewed. Over time, the personal and professional aspects merge and set, so that when faced with a practice problem, the health care provider has a certain understanding of the situation and response to the problem.

The therapeutic interaction between the practitioner and the client happens within the practice context in a specific space and time, which dictates the tools, resources, rules, expectations, and therapy options (Schell, 2014). Other factors related to the practice context and which influence the practitioner-client interaction includes caseload size, reimbursement, and time issues (Schell, 2014). At different times and conditions, different aspects of this triad of therapist, client, and practice context can exert a more predominant influence on the other parts; thereby, affecting or changing therapy outcomes. Factors that influence the therapy interaction are those factors that therapists bring to the table through their personal and professional lenses, and factors related to the

specific practice context. This complex and transactional process illustrates how professional reasoning is more than just what is happening within the practitioner's thoughts (Schell, 2014).

What Chaffey (2009) found interesting about Schell's ecological model of professional reasoning is the inclusion of the client's lens, which may be compatible or in conflict with the therapist's lens. The client also brings to the therapy interaction his or her own personal lens of life experience, personality, and occupational performance issues that necessitated the occupational therapy consult. Clients may have their own predetermined ideas about therapy or the cause of their problem. However, factors related to client context are not reviewed in this present study as the focus is on the therapist, and only indirectly on clients.

In support of Schell's model, Cheung's (2014) dissertation titled *A Model of Behaviour Change in Housework for Women With Upper Limb Repetitive Strain Injury* referenced it as a model that considers the therapist's personal and professional lenses in critical reasoning. Based on Schell's model, Cheung suggested that in order to fully understand therapists' critical reasoning processes, the therapists' personal experiences (i.e., in this study housework) need to be considered in addition to clinical decisions made by therapists about interventions.

In her dissertation study, Thomas (2011) also used Schell's ecological model of professional reasoning as the theoretical framework to examine the influence of personal and practice contexts and pragmatic reasoning on the selection of interventions in treating upper extremity contractures. The methodology for this large study was a cross sectional survey design with 409 subjects. Personal contexts included therapists' skill level, years

of experience, and belief in the effectiveness of the selected intervention. Practice contexts included facility policies, lack of time, lack of access to physical space, high caseloads, lack of insurance coverage, discharge timing, and access to supplies.

According to the results of Thomas' (2011) study, pragmatic reasoning aspects of personal and physical contexts can have an effect on the selection of interventions but not necessarily be a constraint. For the interventions of static progressive splinting, serial casting, electrical stimulation, and positioning in addressing upper extremity contracture there was a strong association between belief in effectiveness, skill level, and the likelihood of selecting these interventions. Although in terms of static splinting and stretching/passive range of motion, the relationship between belief in efficacy, skill level, and likelihood of selecting these interventions was not supported. However, Thomas found that most clinicians employed static splinting and/or stretching/passive range of motion even though they did not necessarily believe in its efficacy for managing contracture.

Thomas (2011) found that the *likelihood of use* was influenced or alternately constrained by skill level, high caseloads, lack of accessibility of materials, or lack of belief in intervention effectiveness. Although the focus of this study was on pragmatic reasoning, it did demonstrate how Schell's ecological model of professional reasoning's (Schell, 2014) concepts of personal and practice contexts can be applied in research. In addition, it identified practice contexts that are commonly recognized as barriers to effective occupational therapy acute care practice (i.e., high caseloads, time constraints, lack of materials, and reimbursement issues).

Occupational Therapy Action Research

The roots of action research can be found in the work of Kurt Lewin and Paulo Freire, but is also grounded “philosophically in liberal humanism, pragmatism, phenomenology, critical theory, systemic thinking and social construction, and practically in the work of scholar-practitioners in many professions” (Reason & Bradbury, 2008, p. 3). Action research involves an iterative cycle of reflection-action-evaluation and was coined the *action research spiral* by Kemmis and McTaggart (2005). With each new cycle of action research, knowledge and understanding about an identified problem is deepened, and based on that knowledge and subsequent actions taken, practice is enhanced or changed.

Most action research studies involve building capacity for the disadvantaged and disenfranchised. Within occupational therapy and other health care disciplines the focus is on health disparities, health education, and inequalities of power for specific communities (Glasson et al., 2006; Jurkowski & Ferguson, 2008; Soh, Davidson, Leslie, & Rahman, 2011; Taylor, Braveman, & Hammel, 2004; Wallerstein & Duran, 2006). However, there are a number of occupational therapy action research studies where acute care occupational therapists and their practices are the subjects of research.

Wilding (2011), and Wilding and Whiteford (2007, 2008) wrote a series of articles on an action research study of Australian acute care occupational therapists. Each article reflected a different phase of the action research process of reflection-action-evaluation. The authors support action research as a method that can result in transformative change (Wilding & Whiteford, 2008). This type of research is seen as a way to increase knowledge and educate through collective and self-reflective inquiry.

Although action research methodology with occupational therapists was well described in these studies, it was not used to address discharge planning issues; rather, the focuses of the studies were on therapists' perceptions of their professional identity and the promotion of occupational therapy.

Wilding and Whiteford's (2007) participatory action research study "Occupation and Occupational Therapy: Knowledge Paradigms and Everyday Practice," described the initial stage of an action research study in which 10 acute care occupational therapists as co-researchers with a wide range of experience participated in individual in-depth interviews where they explored the use of theory, evidence, and occupation in the acute care practice setting, how it impacted their daily practice, and what steps could be taken to improve acute care occupational therapy practice and professional standing. The researchers felt this initial step was necessary to inform the next step of the action research cycle of planning changes to address or improve issues identified or *problematised* by the co-researchers. After this step, the researchers planned to have co-researchers implement the agreed upon plan and then evaluate it to see what changes occurred (Wilding & Whiteford, 2007). This process reflects the reflection-action-evaluation cycle characteristic of action research (Kemmis & McTaggart, 2005).

A participatory action research approach was selected by Wilding and Whiteford (2007) as a means to empower and emancipate the therapists in their study to uncover *new ways of knowing*. They explained the need for this approach because occupational therapists have difficulty articulating the value of occupational therapy services or why they are needed, and to do nothing to change the situation would just keep the status quo,

but “to establish new ways of knowing and acting, would be truly worthwhile” (Wiliding & Whiteford, 2007, p. 186).

The issues identified as the basis for this study were how acute care occupational therapists articulate what they do and the frameworks underlying their attitudes and actions (Wiliding & Whiteford, 2007). The researchers cited occupational therapy *folklore* that as a profession occupational therapy is often misunderstood and unrecognized by clients and other stakeholders. They stated that for years occupational therapy leadership has been urging members to find better ways of promoting occupational therapy and raising its visibility. If clinicians cannot articulate theories or evidence underlying their clinical reasoning, they will not be able to successfully justify their clinical decisions. They described clinical decision making as a process of integrating information from various sources with therapist’s knowledge and experience (Wiliding & Whiteford, 2007).

Themes which emerged included difficulty explaining what occupational therapy is, feelings of being a *square peg*, and being over inclusive in describing occupational therapy (Wiliding & Whiteford, 2007). Participants expressed difficulty describing occupational therapy to others within the hospital system and often felt devalued and misunderstood. They felt the language they used to describe what they are doing would appear too simplistic and did not adequately reflect the underlying problem solving involved, or what occupational therapy focused on was too mundane. For example, as one participant stated “I think people just see us doing the activity and not really analyzing the activity. Not seeing that we’re looking at all these behind the scene things like organization and planning, initiation, safety” (Wiliding & Whiteford, 2007, p. 189).

The participants also felt there were fundamental and philosophical differences between occupational therapy and the medical model. For example, occupational therapists focus on helping patients meet their occupational needs, while the medical model focuses on illness and injury. In other words, a patient may be discharged home when medically stable, but still be unprepared to resume engagement in meaningful occupations. As part of the action research process, participants selected the strategy of changing the way they talk about occupational therapy by replacing function with the word occupation, especially in headings in their documentation (e.g., occupational performance, occupational history), and describing their practice as enabling occupation (Wilding & Whiteford, 2007).

Wilding and Whiteford's (2008) article "Language, Identity and Representation: Occupation and Occupational Therapy in Acute Settings" was a continued report on their previous action research study on acute care occupational therapy and the use of theory and evidence in everyday practice. An additional co-researcher (participant) was recruited so that the researchers had data from interviews of 11 participants. The researchers then divided participants into two groups of five to six participants. The researchers felt that one larger group of 11 participants was not as advantageous as two smaller groups where each participant would have a chance to speak in the group and contribute to the discussion. The groups were informally divided according to convenience with work schedules, diversity in terms of the different units worked at within the hospital, and range of experience. There were two group meetings scheduled each month for a total of 10 group meetings between both groups. Each participant as a co-researcher was asked to attend a maximum of five group meetings. However, not

every participant was able to attend all five meetings due to conflicts with work or time off (Wilding & Whiteford, 2008).

In the initial group meetings, each co-researcher was asked to present a case study of a current client. The group members were then asked to identify what further information was needed and what type of intervention approach should be taken. The aim of these initial group meetings was to explore current practice and the professional or critical reasoning that supported it. Subsequent group meetings were less structured. The final two meetings of the groups were designated for evaluation of the first cycle of this study and included guided discussion questions (Wilding & Whiteford, 2008).

Wilding and Whiteford's (2008) article described the evaluation of the implemented action plan put in place in the earlier study in which occupation replaced the word function in the therapists' communications, in an attempt to better articulate the services they provide. The researchers felt occupational therapy visibility was an important issue as "a profession that is relatively unknown may be poorly placed to ensure that it receives appropriate recognition and remuneration, given that the health service market place is increasingly competitive" (Wilding & Whiteford, 2008, p. 180).

Results of Wilding and Whiteford's (2008) study indicated that participants felt that changes in their language empowered them by improving their confidence, professional identity, and clarity about their role in the hospital setting, their practice was more occupation focused and they became more articulate about occupational therapy. The researchers concluded that the implemented changes in language successfully promoted occupational therapy and increased occupational therapy visibility and awareness of occupational therapy contributions to the acute care setting. The researchers

felt even a simple strategy could empower therapists to engage in strategies that address long standing issues (Wilding & Whiteford, 2008).

Wilding and Whiteford's (2007, 2008) studies validated the power of language and the use of action research as a methodology to examine and enact changes to improve occupational therapy acute care practice. The second phase of the study (Wilding & Whiteford, 2008) provided support for having two smaller groups of 5 to 6 participants involved in group meetings as it allowed each participant the opportunity to contribute to the discussion and express themselves through this type of forum. It also provided support for limiting the group meetings to a total of five sessions for each group (Wilding & Whiteford, 2008).

In "Raising Awareness of Hegemony in Occupational Therapy: The Value of Action Research for Improving Practice," Wilding (2011) continued her action research study exploring acute care occupational therapists' descriptions of their profession and recognition of its contributions in the acute care setting. The researcher felt that based on results of previous phases of the study, occupational therapists may unconsciously be complicit in their own subjugation and poor representation of occupational therapy in the acute care setting, and therefore, contributing to the hegemony of hospital structures and systems.

The previous two articles (Wilding & Whiteford, 2007, 2008) focused on one action research cycle including reflection-action-evaluation. The second cycle highlighted in Wilding (2011) occurred over 18 months with the participation of 15 acute care occupational therapists. As in previous phases described by Wilding and Whiteford (2007, 2008), data collection for the Wilding (2011) study included in-depth individual

interviews and small group discussions; however, evaluation interviews were also conducted at the end of each action research cycle in addition to exit interviews.

Participants in this phase of the Wilding (2011) study indicated that they felt that occupational therapy was not given the respect that it deserves, and continues to be misunderstood by others. The researcher felt that the occupational therapists themselves may be unconsciously contributing to this phenomenon through their passive, self-limiting, conformist behavior within the predominance of a medical model system. The researcher felt this was reflected in their *taken for granted acceptance* of their position in the hospital, and the hegemony that maintained occupational therapists as an invisible and unimportant service. The data also indicated that the participants were further constrained by perceptions that the fault lay with how they practiced, without questioning whether it was due to system or organizational conditions (Wilding, 2011).

The researcher suggested that the way for the participants to improve their confidence, assertiveness, autonomy, and professional recognition was through reflexivity about their practice, attitudes, and behaviors (Wilding, 2011). However, participants felt that because of pressures to be busy and productive, a hospital setting is not conducive to ongoing critical reflection about practice. Wilding also recommended that new students be prepared to be assertive, questioning, and have courage to support their convictions. The Wilding (2011) study provided information on how subsequent action research cycles or spirals build on existing knowledge and help deepen understanding of the identified clinical problem or phenomenon.

In another Australian occupational therapy action research study titled “Utopian Visions/Dystopian Realities: Exploring Practice and Taking Action to Enable Human

Rights and Occupational Justice in a Hospital Context,” Galvin, Wilding, and Whiteford (2011) examined therapists’ understanding of human rights and occupational justice in daily practice. The methodology of this study was collaborative action research, which is a modification of participatory action research. In collaborative action research, the principal investigator or researcher, just like the other co-researchers in the study, is not an outsider but also reflects on his or her own practice, develops his or her own knowledge, and acts to improve his or her own practice while building supportive networks to continue engagement in research activities (Galvin et al., 2011).

Over the course of a year, monthly meetings with nine co-researchers were held using the book *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Wellbeing, and Justice through Occupation* by Townsend and Polatajko (2008), as the basis for group discussions (Galvin et al., 2011). Although different terminology (planning, acting, observing, and reflecting) was used in this study to describe the action research cycle, it was basically the same format of reflection-action-evaluation used in other action research studies (Galvin et al., 2011).

Initially in Galvin et al.’s (2011) study, participants did not associate where they worked with issues of occupational justice or human rights violations as they associated them with conditions of the poor or world conflict areas. However, upon further reflection they identified indigenous Australians and homeless people as populations that may suffer injustices. In addition, even others who do not have financial resources or social support systems may be hindered in their ability to participate in occupations. They also began to reflect on how within a hospital there may be covert injustices through the depersonalization of the environment, so that the needs of individual patients are not

readily acknowledged. For example, when patients wear hospital gowns it takes away from their personal identity adding to their anonymity (Galvin et al., 2011).

With continued discussion during the course of the Galvin et al. (2011) study, the participants began to recognize issues of justice and injustice in their daily practice. The researchers' recommendations were for therapists to increase their awareness of human rights and to be supportive of occupational justice in practice. The study provided further validation of how action research and dialoguing about issues can support communities of practice, increase awareness of new ideas, how they can be applied to the realities of practice and have a transformative effect on practice and academic-clinician collaboration (Galvin et al., 2011).

In "Enhancing Occupational Therapists' Confidence and Professional Development Through a Community of Practice Scholars," Wilding, Curtin, and Whiteford (2012) used the framework of action research to form a community of practice scholars. A community of practice scholars helped bridge the gap between theory and practice through collaboration between clinicians and academicians, where all members of the community contributed to the generation of knowledge. It encouraged clinicians to critically reflect on their *taken for granted* practices, and if they were consistently engaging in best practice. Communities of practice scholars also helped promote professional reasoning within a complex health care environment, where occupational therapy theoretical concepts were applied in real world practice settings. The researchers in this study drew upon Wilding's earlier action research studies as the formation of a community of practice scholars in one Australian hospital, as it provided the participants

the opportunity to discuss practice issues, critically reflect on them, while informing practice and generating knowledge (Wilding et al., 2012).

As in the previous studies, Wilding and colleagues (2012) recruited a group of participants who reflected on their practice, planned practice changes, implemented then evaluated them through group discussion. Twenty-five participants were recruited with a wide range of experience and who worked in diverse practice settings (i.e., mental health, pediatrics, neurology, hand therapy, orthopedics, rural practice, private practice, elder care, and general medicine) from across Australia; however, only 20 participants completed the study. Participants were given the option of attending one of three scheduled monthly meetings. Each teleconference meeting consisted of 6 to 10 participants at one time. The format and topic for each monthly meeting was kept consistent between the groups, and a summary of each meeting was provided to participants to comment or reflect on (Wilding et al., 2012).

The aim of the Wilding et al. (2012) study was to expand on Wilding's work and form community of practice scholars across Australia. The book *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Wellbeing, and Justice through Occupation* by Townsend and Polatajko (2008) was again used as a basis for discussions. The researchers felt this Canadian book could help guide practice in Australia through exploration of new and revised models of practice. Each month participants were assigned selected chapters to read from the book as well as related questions on which they reflected on their practice. These guiding questions were also used as a means of facilitating discussion in the teleconferencing meetings. Participants were also encouraged to participate in reflective journaling, however most of the participants

preferred to post to the group listserv set up specifically for this study instead (Wilding et al., 2012).

The Wilding et al. (2012) researchers concluded from their findings that a community of practice scholars was a good strategy for professional development, professional identity, greater job satisfaction, and a greater feeling of support. This study illustrated how action research can lead to the formation of a community of practice, and how being a member of a community of practice can promote professional development, networking, and support with practitioners who have similar professional interests and practice concerns (Wilding et al., 2012).

Reed and Hocking (2013) in their article “Re-visioning Practice Through Action Research” also conducted an action research study that focused on communities of practice. The focus of their study was to find strategies for senior occupational therapists (as managers and supervisors) to disseminate new knowledge to their staff that could potentially transform practice. The researchers discussed how occupational therapy is undergoing re-visioning as a profession and termed it occupational renaissance (Reed & Hocking, 2013). This new vision is aligned with ICF’s (World Health Organization, 2015) focus on participation outcomes. Occupational therapists must adapt to new health reform challenges that can constrain or shape the profession.

In the Reed and Hocking (2013) study, six New Zealand occupational therapists as co-researchers formed a collaborative community of practice through participation in the action research process. As in Wilding’s (2011) and Wilding et al.’s (2012) studies, researchers of the Reed and Hocking (2013) study also used Townsend and Polatajko’s (2008) book as part of their study. However, this study was only conducted over a 9-

month period of 2-hour monthly teleconferencing meetings. All co-researchers planned, implemented, and reflected on actions taken at their own practice sites. In addition, the principal investigators also shared their reflections and written summaries about emergent study findings with the co-researchers (Reed & Hocking, 2013).

The Reed and Hocking (2013) action research study helped reenergize the participants to make practice changes, increase their confidence with using occupation in their language when communicating with other team members, helped with staff development and supervision sessions, and how using theoretical frameworks can help clarify occupational therapy. This study demonstrated how action research can bridge theory and practice, and helped the participants in this study develop strategies for disseminating new knowledge with the potential to transform their practice and increase their confidence with staff supervision (Reed & Hocking, 2012).

In “New Graduate Therapists in Acute Care Hospitals: Priorities, Problems and Strategies for Departmental Action,” Cusick, McIntosh, and Santiago (2004) undertook an action research study to explore the perceptions of acute care occupational therapists working with new graduates in their departments. Their aim was to find out what types of support strategies needed to be developed to address the special needs of novice practitioners employed in an acute care practice setting, and to prevent high turnover. This study had three phases—(a) identify the problem; (b) discussion about why it was a problem; and (c) a Delphi approach (with participants as the anonymous panel of experts), upon which strategies to address the problem were developed (Cusick et al., 2004).

Cusick et al. (2004) identified issues and grouped them as (a) retention of new graduate staff; (b) new graduate function in clinical roles; (c) new graduate function in the occupational therapy department; and (d) whose problem was it (i.e., problems for new graduates themselves, or problems for existing staff). This study supported the use of action research as a method that can generate knowledge about decision making, and effect change for occupational therapy departments and teams, including improved retention and clinical roles of new graduates (Cusick et al., 2004).

Egan et al. (2004) conducted an occupational therapy action research study, that although was not specifically targeted to acute care therapists, it did highlight many of the benefits and pitfalls of this research approach. In addition, Egan et al. based their action research methodology on Stringer's approach, the same method selected by the researcher for the current dissertation study. Although the researcher used Stringer's (2014) updated edition for the current study, the basis was the same. Egan et al.'s (2004) study consisted of three steps that initially consisted of collecting information from participants about the problem, then data analysis and theorizing where participants reflected on their practice, and lastly in the third step action was taken to implement solutions that the group had developed.

A WebCT platform for the Egan et al. (2004) study was provided by the University of Ottawa; however, one of the groups switched to using regular email and another group preferred to have a live chat meeting through an MSN Chat Room instead. Each participant also took part in a telephone interview after the groups were concluded. Fifty-one participants initially participated in this study; however, by the conclusion of the study there appeared to be a 50% attrition rate. According to the researchers, the

study began to lose momentum around the fourth month when the focus of the group shifted to selection of a question for the group to address, and then making decisions about which tasks to undertake to move the study forward.

The aim of Egan et al.'s (2004) study was to determine if online action research was a good mechanism to facilitate the use of research in the practice of Canadian occupational therapists who worked in similar clinical settings, or for therapists who work in isolation from other clinicians. Major barriers of time commitment coupled with technical issues discouraged many participants from continuing with the study. Despite barriers, participants stated they enjoyed being in contact with other therapists, and being a part of this study increased their awareness and motivation for research utilization in practice, knowledge of resources, and how to apply theories they learned in school to real practice. The researchers concluded that online action research has potential to increase research utilization among occupational therapists, but the process needs to be better structured and refined (Egan et al., 2004).

Although an older study, in Mattingly and Gillette's (1991) "Anthropology, Occupational Therapy, and Action Research," they discussed the action research component of the joint AOTA and AOTF occupational therapy Clinical Reasoning Study, and highlighted the potential of conducting this method of research within a rigid hospital system in which therapists felt they had few resources and little power. As the authors pointed out, therapists could not change the length of shortened hospital stays, but they could strengthen their clinical reasoning skills to improve practice and increase confidence in their abilities. As Mattingly and Gillette concluded, increased professional

confidence is important for professions such as occupational therapy, where other disciplines may not understand or value our contributions.

Summary

The above literature is representative of the many issues and barriers involved in acute care discharge planning and underscores the complexity of the process. Discharge planning involves many factors including (a) the physical and cognitive abilities of the patient; (b) constraints of the institutional environment including short hospital stays; (c) quick discharges; (d) health care regulations and policies; (e) constraints of reimbursement sources; (f) the knowledge, skills, and expertise of the therapists including their critical reasoning abilities; and (g) differing perceptions of what it means to be client centered in discharge planning (Connolly et al., 2009; Jette et al., 2003; Kasinskas et al., 2009; Maitra & Erway, 2006; Moats, 2006, 2007; Moats & Doble, 2006; Nalette, 2010).

Poor discharge planning has been associated with poor communication, lack of multidisciplinary teamwork, inconsistent assessment standards, varying levels of risk tolerance (Bowles et al., 2008), and working within an inflexible hierarchical bureaucratic systems resulting in poorer patient outcomes as patients are discharged with unmet needs and at increased risk of adverse events. Readmissions may be unnecessary if discharge planning were more effectively done (Wong et al., 2011).

Many studies have advocated greater communication and collaboration among stakeholders, inclusion of patients and families in discharge planning, and the use of discharge interventions and standardized assessments to help improve the discharge planning process and its accuracy (Atwal & Caldwell, 2003a; Bauer et al., 2009; Hickman et al., 2007; Jette et al., 2014; Matmari et al., 2014; Pethybridge, 2004; Wong et

al. 2011). Although these different strategies have been explored in the literature, there remains limited research on what actions can be successfully undertaken to remain client centered and improve client outcomes within the acute care discharge planning process. These issues are increasingly important due to the uncertainty of the new health care law, the current economic climate with increasing health care costs, and a burgeoning elderly population. Discharge planning also continues to have implications for readmission rates, quality of life issues, patients' level of satisfaction, and allocation of limited health care resources. Empowering acute care occupational therapists to take action to improve their discharge planning skills can have a direct impact on generating knowledge to improve patient outcomes, quality of care, and highlight the contributions of occupational therapy in this process.

Table 2.1

Literature Findings

Authors and date	Location	Participants	Method	Study purpose	Findings
Atwal & Caldwell (2002)	United Kingdom	48 health care professional (the different disciplines and the number of participants from each professional group was not spelled out, however nursing, occupational therapists, and case managers were referenced. Also difficult to determine because there were different parts to the overall study)	Action research-interview, audit of case notes and analysis of care pathway	Explore feasibility of using an integrated care pathway for orthopedic patients. Part of a larger study.	Little evidence that using integrated care pathways improved interprofessional communication or relationships. Problems with discharges more organizational than professional.
Atwal & Caldwell (2003a)	United Kingdom	10 multidisciplinary discharge planning team members as 'experts'. Group consisted of: 3 nurses, 2 occupational therapists, 2 social	Delphi study	Exploring ways to improve multiprofessional team discharge planning on an orthopedic ward (as part of larger action research study).	Delphi approach is a successful and democratic method to achieve consensus on finding ways to improve multidisciplinary teamwork on issues related to discharge planning.

		workers, 2 orthopedic consultants, 1 discharge manager			
Atwal & Caldwell (2003b)	United Kingdom	10 Occupational therapists & 2 elderly patients	Case study- interviews and analysis of videotapes	Part of a larger study examining the subjects' perceptions of discharge planning and multidisciplinary teamwork.	In discharge planning, occupational therapists can unintentionally violate occupational therapy professional conduct and code of ethics: ethical principles of respect for autonomy, beneficence, non-maleficence and justice.
Atwal, McIntyre, & Wiggett (2011)	United Kingdom	7 occupational therapists and 5 physical therapists	Qualitative- semi- structured interviews; case study/clinical vignette	Explored therapists' perceptions of older adults in acute care and risks associated with discharge.	Perception of risk has an effect on discharge decision making. Factors that influence include levels of patient functioning, mental capacity and safety.
Bauer, Fitzgerald, Haesler, & Manfrin (2009)	United States	Number of studies reviewed unknown (English language studies published after 1995)	Nursing literature review	Review of evidence of discharge planning practices and the experiences of frail elderly patients and their carers.	Discharge planning practices can be improved with the inclusion of patients and their families, improved communication between health care workers and families, and with post-discharge support provided. Interventions should begin well before discharge. A direct correlation was found between the quality of

					discharge planning and hospital readmissions.
Blaga & Robertson (2008)	New Zealand	72 acute care occupational therapists	Mixed methods, cross sectional survey analyzed quantitatively through descriptive statistics, and qualitatively by looking for emerging themes.	Examine the nature of acute care occupational therapy practice in New Zealand	Occupational therapists working in acute care view their work positively, and their input was of value in ensuring a safe discharge for patients. They also viewed occupational therapists main role as assessing and planning for discharge, and although they were trained to do more, time constraints and large caseloads prevented them from engaging in interventions. In addition, they have to engage daily in making quick clinical decisions related to a wide variety of pathologies.
Bland, Whitson, Harris, Edmiaston, Tabor, Fucetola, . . . Lang (2014)	United Kingdom	Records of 2,738 acute stroke and TIA patients	Descriptive analysis	Examining whether scores on standardized assessments from initial occupational and physical therapy evaluations can guide discharge recommendations	Patient discharge dispositions included: home with no services, home with services, acute inpatient rehabilitation facility (IRF), and skilled nursing facility (SNF). Patients were able to be divided into groups/clusters based on their assessment scores, with Cluster A as least impaired and Cluster D most impaired. Cluster A - for half the group

					the discharge recommendation was for patients to return home with no services. For Clusters B-D ~75% of the recommendations were to IRF. Scores from standardized assessments from initial occupational and physical therapy evaluations can be used to guide discharge recommendations.
Boronowski, Shorter, & Miller (2012)	Canada	89 community hospital patients (rehab and transitional care)	Quantitative study comparing the OTDNS and the Functional Independence Measure (FIM) and Functional Autonomy Measurement System (SMAF).	Looking at measurement properties (reliability and validity) of the Occupational Therapy Discharge Needs screen (OTDNS) – screening tool developed to identify patients with complex discharge needs.	Validity - OTDNS had an inverse relationship with the FIM but a positive relationship with the SMAF. There was good inter-rater reliability, after instructions and definitions were revised. The OTDNS had good sensitivity in determining need for follow up occupational therapy in the community and use of resources after discharge.
Bowles, Ratcliffe, Holmes, Liberatore, Nydick, & Naylor (2008)	United States	8 outside multidisciplinary experts and 4 local clinicians	Comparative case study	Comparison of discharge recommendations for 350 elderly patients and review of outcomes after 12 weeks	Experts made referrals for 81% of patients, and did not make referrals for 19%, while clinicians referred 29%, but did not recommend referrals for 71%. 47% of referrals were in agreement. Experts were 18

					<p>times more likely to recommend post-discharge services for patients than hospital clinicians ($p < 0.001$). Experts identified 183 additional patients for services, but experts had more time and better information on which to base their recommendation than the clinicians. Clinicians tended to make referrals for patients who were older, had less help available at home, longer lengths of hospital stay, or had surgery. Among participants there was a feeling that discharge planning was disjointed as there was no standardization in terms of policies or protocols.</p>
Brown, Craddock, & Greenyer (2012)	United Kingdom	7 elderly patients	Prospective qualitative study-1 hour semi-structured interviews (thematic analysis of transcripts)	Explore patients' perceptions of the InReach hospital to home transition program	<p>Three themes identified: patients' need for knowledge and information, autonomy and control, and psychosocial needs on discharge. Researchers found that patients had limited understanding of occupational therapy and confusion remained between occupational & physical</p>

therapy services. They viewed discharge planning as haphazard, anxiety producing, and did not understand what was going on. They felt little information was provided about post-discharge services and they felt abandoned. However, having continued care from occupational therapists they already knew from the hospital was reassuring and continuity between settings was valued.

Campbell, Seymour, Primrose, Lynch, Dunstan, Espallargues, & Acmeplus Project Team (2005)	Multi country study: Poland, United Kingdom, Italy, Greece, Spain, and Finland	1,626 patients	Prospective cohort quantitative study. Compared by discharge destination (home, setting other than home, death in hospital)	AcmePlus project - identify which of 7 factors facilitated discharge planning, and helped predict discharge destinations for elderly patients	There was a statistically significant relationship between all the 7 predictor factors and discharge disposition, with physical functioning as the best single predictor. Geriatric giants (group of conditions that contribute to hospital admissions - issues with falling, mobility, cognition, bowel/bladder function) were stronger predictors ($p < 0.0001$) of post-discharge institutionalization than age itself, but that each factor needs to be considered
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individually in terms of impact on discharge planning. Cognition ($p<0.0001$) and level of physical functioning ($p<0.0001$) were the best predictors of mortality, discharge disposition, and length of stay for older adult patients. Researchers concluded that physical functioning and cognition were important factors to consider in addition to patients' diagnoses.					
Chan, Sandel, Jette, Appelman, Brandt, Cheng, TeSelle, . . . Rasch (2013)	United States	222 stroke patients	Prospective cohort study	Exploring whether discharge destination has an impact on stroke recovery.	Discharges: 36% returned home with no services, 22% had home health or outpatient services, 30% were discharged to inpatient rehabilitation facility (IRF), and 13% to a skilled nursing facility (SNF). When comparing patients six months post-stroke the patients who had an acute inpatient rehabilitation stay scored 8 points higher (AM-PAC) across the domains of basic mobility ($p<0.0001$), daily activities ($p<0.0001$) and applied cognition ($p=0.007$) than those patients with a stay at in a subacute rehabilitation

Chang, Ni, & Jette (2014)	United States	417 neurologic, LE orthopedic trauma, and medically complex patients discharged to inpatient rehabilitation, SNF, OP, or HH	Correlational analysis of prospective longitudinal study, using AM-PAC and Short Portable Mental Status Questionnaire as outcome measurements	Exploration of whether ICF's domains of activity limitations can help predict discharge disposition.	unit. They found that discharge destination does matter, as the IRF patients made the most gains (with higher scores on the AM-PAC).
					At 1 month, there was a positive correlation between cognitive status and 2 domains of activity (basic mobility and daily activity). There was an association between AM-PAC basic mobility scores and a discharge home ($p<0.05$), indicating that patients with good mobility were more likely to be discharged home. Basic mobility functioning was found to be the best predictor for determining discharge home vs. non-home setting. Therefore, level of basic mobility is an important factor in discharge planning.
Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, ...Deaton (2009)	United Kingdom	27 mix of staff that included 11 nurses, 15 allied health professionals, 5 social workers and 1 physician	Qualitative focus groups (3)	Explore hospital based health professionals perceptions of the discharge planning process	Themes that emerged: Conflicting pressures on staff (having patients stay in hospital vs. getting patients out of hospital) and casualties arising from conflicting pressures on staff. These were attributed to hospital

					inflexibility, poor communication, dominance of medical model approach, complex needs of patients, lack of community services, and patients being systematized, Staff felt were victims as wanted to do a good job for patients, but much outside their control, and with a sense of deprofessionalism.
Craig, Robertson, & Milligan (2004)	New Zealand	34 acute care occupational therapists working in 3 different hospitals in New Zealand	Mixed methods study; Questionnaire (questions based on results from an earlier Australian study) analyzed using descriptive statistics; narrative data analyzed for themes.	Exploration of the nature of acute care occupational therapy practice in New Zealand	Subjects expressed frustration over poor referral system, ineffective communication, other team members not understanding patient discharge needs, and poor understanding of occupational therapy's role. However, many of the subjects felt their input valued and they were respected. Effective communication is needed for a positive working environment. Occupational therapists provide services needed for successful discharge planning, but in order to be effective they have to have good communication with other team members, and need to be

					able to quickly assess and problem solve within a fast paced or time pressured environment.
Crennan & MacRae (2010)	United States	10 acute care occupational therapists	Mixed method ethnographic study consisting of a questionnaire to collect basic participant information (quantitative) and a one on one interview (qualitative) – core method of data collection	Identify effective discharge assessments for elderly patients, use of client-centered practice and critical reasoning skills in acute care occupational therapy discharge planning.	Discharge decision making is a complex process that needs to be individualized to each patient. Discharge recommendations are based on many factors including home support, patient performance of daily activities, and safety. Non-standardized functional-based assessments are predominantly used in making discharge decisions, however standardized assessments are used but inconsistently. A client-centered approach was also inconsistently employed.
Crum (2011)	United States	28 orthopedic patients (s/p THR, TKR) – 17 in experimental group and 11 in control group	Mixed method using a survey. Quantitative - descriptive statistical analysis using the Readiness for Discharge Survey;	Determining whether an evidence based IADL program improved orthopedic patients' preparedness for discharge, as compared to traditional program.	The IADL group had higher scores on preparedness for discharge in the areas of IADLs (as measured by the Readiness for Discharge Survey). The groups were approximately equal in terms of preparedness to be discharged from acute care (control group 64% and the

			Qualitative – analysis of open ended questions		IADL intervention group 67%) reported feeling ‘prepared’ or ‘very prepared’ for discharge. 55% of the comparison group felt very prepared for discharge, while only 20% of the IADL group felt very prepared for discharge. Researcher felt this may be because IADL group more focused on completing higher level ADLs then the comparison group that was mainly concerned with BADLs; or differences may have been due to differences demographically between the two groups.
Cusick, McIntosh, & Santiago (2004)	Australia	Phase one included 24 participants, Phase two 36, and Phase three had 19 participants for round one; for round two there were 27 participants. Participants included new therapists, department	Action research cycle + delphi approach	Explore perceptions of acute care Occupational therapists working with new graduates	Fifteen important issues were identified with departmental strategies suggested. Delphi technique to generate priorities for this action research study was deemed successful and is researchers recommended this method for setting priorities that are inclusive and reflect wide ranging viewpoints.

		manager, and experienced therapists			
Durocher & Gibson (2010)	Canada	Both authors (occupational and physical therapy) as researchers reflecting on a case from the first author. Additional information obtained from client.	Qualitative—normative ethical analysis of clinical case study using thick description and author reflexivity	Exploration of common ethical issues with discharge planning of older patients	Health care teams struggle with the balance between protecting patients from harm and supporting informed choice. Need to increase communication to identify and minimize risks, and help patients determine their personal level of acceptable risk.
Duxbury, DePaul, Alderson, Moreland, & Wilkins (2012)	Canada	209 stroke patients	Mixed methods—semi-structured interview and survey	Identify characteristics and needs of stroke patients discharged from acute care with unmet needs. Part of a larger longitudinal study	Subjects were divided into 3 groups: those needing post-discharge occupational therapy, those receiving it, and those who did not need it or receive it. 13% of patients reported they were discharged home with unmet needs and had more dependence in ADLs (before and after stroke) and lower FIM scores as compared to the other 2 groups ($p < .05$). Patients reported unmet needs in the areas of UE function, leisure, ADLs, and resumption of social roles.
Egan, Dubouloz,	Canada	4 groups of 12-14 occupational	Action research (1	Determine if online action research was a good	Meeting online has potential in facilitating use of research

Rappolt, Polatajko, von Zweck, King,... Graham (2004)		therapists (25 occupational therapists across Canada)	action research cycle)	mechanism to facilitate the use of research by Occupational therapists practicing in similar settings.	evidence amongst practitioners, but there were many barriers to success (i.e., attrition, time commitment)
Galvin, Wilding, & Whiteford (2011)	Australia	9 hospital occupational therapists from different departments	Collaborative action research – monthly meetings and discussion	Examined therapists' understanding of human rights and occupational justice in their daily practice. Used <i>Enabling Occupation II</i> by Townsend and Polatajko (2008) to facilitate discussion.	Themes that emerged were invisibility of human rights in an Australian occupational therapy setting and the dissonance between the ideal and reality of human rights practices in routine occupational therapy practice. Collaborative action research can help increase occupational therapists' awareness of human rights issues and actions they can take to ensure occupational justice.
Gorman, Wruble, Johnson, Bose, Harris, Crist,. . . Bryan (2010)	United States	254 experienced PTs	National survey: The Acute Care Physical Therapy Practice Analysis Survey	Exploration of the specific skills, knowledge, and behaviors required of acute care physical therapists–practice analysis.	Physical therapists practicing in acute care need to have in depth knowledge of working with patients with acute illnesses throughout the lifespan and across multiple body systems, as well as knowledge of medical and surgical interventions, and through synthesis of all information be able to develop

					and implement an evidence based individualized plan of care. They must also be proficient in communication, prevention of secondary complications, advocates for the next level of care, as well as have an understanding of the fluctuation in patient presentations, impact of comorbidities, knowledge of patient health preferences and beliefs, and availability of resources.
Grimmer, Dryden, Puntumetakul, Young, Guerin, Deenadayalan, & Moss (2006)	Australia	148 patients (60+)	Mixed method: quasi-experimental (each hospital acted as its own control), and qualitative grounded theory	Comparison of patients' perceptions of preparedness for discharge between those who received an additional patient-centered checklist, and those who underwent standard discharge practices.	Use of checklist improved patients' preparedness for discharge especially when family members or friends were involved, so could be a good tool for discharge planning. There was a strong association between the use of the checklist and preparation for discharge for those subjects with a carer ($p<0.05$) as compared to the rest of the subjects in the sample ($p=0.08$). Using the checklist can help raise awareness of a range of practical issues for returning home for patients

					and families. Top themes included energy conservation, core ADLs, and family/friends as carers. Patients felt checklist should be available immediately upon admission. Researchers suggested use of checklist may head off some post-discharge problems, but due to the shortness of hospital lengths of stay, premorbid poor states of health, and especially for those who were alone, the checklist was not as beneficial as it could have been.
Hager (2010)	United States	30 medical/surgical patients	Quasi-experimental pilot study (nursing) using the author's Perceived Readiness for Discharge Scale (questionnaire and phone calls)	Exploration of patient preparedness for discharge through an intensive interdisciplinary discharge intervention program, and whether patient satisfaction was related to perceptions of preparedness for discharge	Increasing patient preparedness and inclusion of patient and families including early identification of goals and barriers to discharge, has the potential to improve patient satisfaction and confidence, while also decreasing readmission and adverse events. The intervention group scored higher on issues related to diet, medication management, activity restrictions, disease management, who to contact if problems arose, availability of

<p>post-discharge resources. The added discharge intervention program felt better prepared for discharge ($p<0.01$) and managing their medical condition ($p=0.07$) (i.e., wound care, respiratory treatments, exercise, medications). The intervention group also had better awareness of their post-discharge treatment plan including medical follow up ($p<0.05$) and available community services ($p<0.04$). For the intervention group there were also no reports of adverse events or readmission within two weeks post discharge.</p>					
Hickman, Newton, Halcomb, Chang, & Davidson (2007)	United States	26 controlled trials met criteria	Nursing literature review	Review of evidence based interventions for elderly patients in the acute care setting.	Essential elements and interventions for the optimal care of elderly patients in acute care includes a multidisciplinary team approach (including those with expertise in gerontology), targeted assessments to prevent complications, increased focus on discharge planning, and improved communication

Holm & Mu (2012)	United States	7 experienced acute care occupational therapists (working in acute care 5+ years and 8 years as an occupational therapist)	Phenomenological study	Explore perceptions of experienced acute care Occupational therapists and factors they considered when engaging in discharge planning for the older adult patient	among health professionals along the continuum of care. Five themes emerged: Looking at the total picture; prioritizing client-centered collaborations; emphasizing cognitive functioning; enhancing occupational engagement; and framing assumptions about elderly discharge planning. Priority areas for assessment: self-care skills, client values, and cognitive status, in addition to the customary consideration of the patient's support system, prior level of function, and current living situation as well as assessment of areas related to occupational performance. Experienced therapists had a more comprehensive client centered and occupation based approach and used information from multiple sources in discharge planning.
Huby, Brook, Thompson, & Tierney (2007)	Scotland	22 older patients and 11 hospital health care providers	Ethnographic study	Examined the perceptions of decision making and participation in discharge	Themes: participation and independence. Despite using similar terms, patient and staff's

		(including 1 occupational therapist)		planning of older patients and other stakeholders	conceptualization of decision making and priorities in discharge planning differed, with patient's preferences being invisible. Procedurally driven care including assessments and structured interactions prevented the engagement and negotiation between patients and staff. Researchers suggested that it is an ethical imperative to have patient and carer concerns at the center of decision making.
Huby, Stewart, Tierney, & Rogers (2004)	Scotland	22 older patients	Qualitative case study analysis (pilot study)	Explore the organizational context and older patient's participation in discharge decision making, and issues of shared decision making and risk management	There is a link between participation in decision making and risk management. Discharge planning relied heavily on patients' cognitive and physical abilities. Staff had little confidence in patients' abilities to participate in discharge decision making. Patients were prevented from expressing their views, and a poor understanding of the discharge process. As a result difficult decisions about risk were not openly discussed. Not having patients and staff

					engaged in active decision making produced new risks. The researchers recommend setting up an environment of trust and negotiation about risk.
Jette, Grover, & Keck (2003)	United States	7 physical therapists and 2 occupational therapists	Grounded theory	Exploration of the discharge decision making process of occupational and physical therapists working in acute care	Four constructs were identified as influencing discharge decision making and included: patients' functioning and disability, patients' wants and needs, patients' ability to participate in care, and patients' life context. In making discharge recommendations, information about the patient is also filtered through the therapist's experience, health care regulations, and the opinions of other team members.
Jette, Stilphen, Ranganathan, Rassek, Frost, & Jette (2014)	United States	Review of 92,899 patient electronic medical records from the Cleveland Clinic Health Care System that were seen by their 90 physical therapists and 45 occupational therapists who	Retrospective & observational study – patient demographic and data from AM-PAC were analyzed using	Determining whether the “AM-PAC 6 Clicks” mobility and ADLs assessment is effective in predicting discharge placement (home or to an institutional setting).	There is evidence to support the accuracy of the AM-PAC 6 Clicks basic mobility and ADLs assessments in predicting patient discharge setting. There was an 83% accuracy rate between occupational and physical therapy discharge

		worked in acute care.	descriptive statistics		recommendations and actual discharge dispositions.
Kasinskas, Koch, & Wood (2009)	United States	100 acute care physical therapists actively working in 24 CT hospitals	Survey - scores were assigned based on rankings of answers.	Examination of the role of physical therapy in acute care and which factors most influenced their recommendations for discharge.	Physical therapy consults often were not ordered until the day of discharge, negating any potential benefits of physical therapy interventions during hospitalization. Physical therapists use their professional judgment when making decisions about the best discharge disposition for their patients. The data also suggested that insurance companies were not directing discharge disposition. Transferring and ambulation were ranked as the most important factor to consider when making discharge recommendations. According to 54% of respondents it was the most important factor and according to 23% it was the second most important factor. Cognition and having assistance or someone at home were the next two most important factors. The researchers coined this as the Big Three (ambulation and

Luker & Grimmer-Somers (2009)	Australia	50 patients who were admitted for acute stroke	Mixed method - retrospective medical record audit for demographic information, and to compare admission and discharge data using the FIM and FAM as a measure of patient function. The data from this study was compared to a data previously collected in 2005. Semi-structured interviews were also conducted	Exploration of allied health staff compliance with discharge guidelines (evidence-based National Clinical Guidelines for Acute Stroke Management), any shortfalls in post-discharge support tied to discharge planning practices, and their relationship to post-discharge experiences of patients and their carers.	mobility, cognitive status, and having someone available at home to assist). Not all patients received guideline based care, as there was variation in compliance with discharge guidelines among allied health professionals and that did not always translate into improved patient outcomes. There was better compliance to guidelines for patients with complex strokes. It is not always possible to predict what patients' post-discharge experiences will be when they are still hospitalized. There was a 40% shortfall between what were predicted to be patient's post-discharge supports and what they actually received. For 32% of patients their post-discharge needs increased over time. Why some professionals prioritized certain patients by complying with guidelines was unknown. Although it was felt that a pre-discharge home visit would allow therapists to
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			with subjects at 6 weeks and 6 months after discharge.		better anticipate patients' post discharge needs, statistically it did not seem to have an effect ($p>0.05$) despite the trend for patients with a pre-discharge home visit being more than five times more likely to avoid discharge with unmet needs, in comparison to those patients who did not have a pre-discharge home visit.
Maitra & Erway (2006)	United States	11 occupational therapists & 30 patients	Cross sectional survey of occupational therapists and their clients. Data was analyzed using descriptive statistics and one way ANOVA comparing differences in opinion of client-centered practice in 4 different	Examination of the perceptions of client-centered practice between occupational therapists and their clients	There was a perceptual gap between occupational therapists and their patients and how they both viewed their role in client-centered practice. Occupational therapists thought they were engaged in client-centered practice, but their patients had mixed perceptions about their role as active participants in client centered care and were unaware of this approach. There was a significant difference noted in clients' knowledge of client-centered practice and their occupational therapy goals across the facilities. Clients from both nursing

settings (long term care, outpatient, inpatient hospital and nursing homes).

homes and outpatient hospitals were significantly more aware of their occupational therapy goals than clients from long-term-care or rehabilitation facilities. Clients from inpatient hospitals showed a trend of greater awareness of their occupational therapy goals than the clients from long-term-care or rehabilitation facilities. The occupational therapists across all settings felt they engaged their clients in discussion about their goals and plan of care, but also indicated there were barriers to client centered care. Barriers to client-centered practice included: clients with decreased cognition, clients who did not want to contribute to goal setting and expected the therapist to do it for them, decreased facility productivity, clients who are unable to communicate their concerns, difficulty of practicing in an environment where the client's personal goals may not be the

					<p>focus of treatment on the health care team's agenda, and clients who are not interested or motivated to be independent.</p> <p>Inpatient hospital therapists had the strongest trend for not engaging in client-centered practice and had the most difficulty in attempting to do so.</p>
Masley, Havrilko, Mahnensmith, Aubert, & Jette (2011)	United States	18 acute care physical therapists	Grounded theory	Exploration of the role of acute care physical therapists, their reasoning processes, and the context for provision of physical therapy services in the acute care setting	<p>Eight themes emerged including: collection and analysis of medical information, application of specialized physical therapy knowledge, communication to gain information, communication to provide information, continual dynamic assessment, professional responsibility, complex environment, and decision making for patient care. Critical reasoning of physical therapy in this setting is a dynamic process that must be accomplished rapidly in the complex and fast paced environment of the acute care setting. The major concerns for</p>

Matmari, Uyeno, & Heck (2014)	Canada	39 acute care physical therapists	Mixed methods. Cross sectional study using an online questionnaire. Demographic information and ranking of factors analyzed with descriptive statistics; open ended questions coded for themes.	Explore the discharge planning process from the perspective of acute care physical therapists.	physical therapists in this study were safety and mobility. Discharge planning begins on the day of admission. In making discharge recommendations, respondents overwhelmingly selected mobility, discharge destination, and family support as their number one factors to consider in making discharge recommendations. Communication among team members was also ranked high in importance. Respondents felt pressured for early discharges and by discharge policies. Respondents were also dissatisfied with the discharge planning process and felt disrespected when their recommendations were not followed or the patient was discharged to an inappropriate setting or no appropriate disposition existed. They also had no say in determining the discharge date. Better team communication and resource allocation was recommended.
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Mistiaen, Francke, & Poot (2007)	Netherlands	Review of 15 systemic reviews	Meta review	Identify discharge planning interventions that were most effective in preventing or decreasing risk of post discharge problems	There is some evidence that discharge interventions are helpful if they include an educational component, or when discharge planning is combined with discharge support. However, as a whole there was little to no evidence that discharge interventions (included in these reviews) influence discharge disposition, hospital length of stay, cost or level of patient functioning or dependence at discharge.
Moats (2006)	Australia	10 Occupational therapists	Qualitative – semi-structured interviews	Explore institutional factors influencing discharge accommodation decision-making with older people from the perspectives of the Occupational therapists	The institutional environment does have an effect on discharge planning, as the medical model (with physician driven discharges), time constraints, and the pressure for quick decisions in discharge planning are obstacles to a client centered approach. Many of the respondents felt it is difficult to be client centered in acute care. The researcher recommended that decisions about long term needs should not be made in acute care but

					rather out in the community or at longer stay facilities where there is time for a negotiated client centered approach.
Moats (2007)	Canada	10 Occupational therapists working in acute care and rehab	Qualitative - interviews	Exploration of occupational therapy models of decision making in discharge planning in acute care, professional commitments to client centeredness and enabling occupation	Therapists often engage in negotiated decision making, and at times must balance competing issues of safety and autonomy. Despite valuing client centeredness, patients are sometimes excluded and occupations neglected. In addition, there was also evidence that therapists used coercion, intimidation, and persuasion in enacting professional dominance over patients in agreeing to discharge recommendations. Researcher recommends a negotiated model of decision making for frail elderly patients that will help enable patient engagement in occupations.
Mukotekwa & Carson (2007)	United Kingdom	29 people consisting of a mix of hospital staff and patients (10 nurses, 2 managers, 1	Qualitative nursing study using telephone interviews and	To gain a better understanding of the complexity of discharge planning practices in a general surgical ward.	Discharge planning is a complex process. Items identified to improve discharge planning included greater cooperation among involved health care professionals,

		<p>dietician, 2 Occupational therapists, 3 PTs, 1 palliative team member, 2 social workers, 3 pharmacists and 5 patients)</p>	<p>Checkland's Soft Systems Methodology</p>		<p>better utilization of nursing staff, adoption of information and communication technologies, and a more holistic approach by nursing to patient care. This study offers support for a soft systems methodology in health care research.</p>
Nalette (2010)	United States	<p>Author was presented with a common case scenario of an experienced acute care PT</p>	<p>Case study analysis with an applied ethical approach</p>	<p>Exploration of the moral dilemmas and constrained physical therapy practices in making discharge recommendations in the acute care setting</p>	<p>An ethical approach and moral brief can be sought by answering the following questions: what are the central moral issues of the presented dilemma; what are the conflicts in the case that make it an ethical dilemma; who are the major stakeholders in the dilemma; what are some foreseeable consequences of the possible choices in the dilemma; what are some foreseeable principles involved in each decision; what are some viable alternatives to ethical courses of action; what are some important background beliefs that should be considered in the dilemma; what are some of the initial intuitions and feelings a this</p>

<p>dilemma; what choices would be made if the therapist were to act in character in the ethical dilemma; what does the profession's <i>Code of Ethics</i> say regarding the relevant moral issues in the dilemma; and what is the decision, and were there any afterthoughts. Ethical dilemmas occur when PT practice is constrained when there are insufficient resources available to meet patients' needs, and patients receive less care than they need. Providing less care to patients is unethical. Constrained practice can be countered by using compassion and finding a moral alternative. PTs have a responsibility to uphold social justice by actively influencing organizational policies and procedures, and societal norms and culture.</p>					
Nosbusch, Weiss, & Bobay (2010)	United States	38 exploratory and descriptive qualitative studies from 1990-2009	Nursing integrative literature review	Review of nursing perceived barriers to discharge planning and patient preparedness	7 themes were found across studies: intra- and interdisciplinary communication; systems and structures; time; role

confusion; care continuity; knowledge; and the invisibility of the staff nurse role in discharge planning.

There is much literature that discusses the barriers to discharge planning but limited research on interventions that address these obstacles. Better patient-centered discharge planning can help address adverse events experienced by patients after discharge, and help facilitate the transition hospital to home.

Pethybridge (2004)	United Kingdom	9 hospital teams (different teams included some members of occupational therapy, physical therapy, rehabilitation assistant, nursing, ward sister, social worker, discharge coordinator, consultant, registrar, house officers, a discharge	Grounded theory (focus groups, interviews, and observation on two wards and with a supported discharge team)	Exploration of factors that promote or inhibit multidisciplinary team discharge planning	Effective discharge planning requires good leadership, effective communication between team members, and teamwork based on sharing, developing trust, and agreeing to responsibilities, roles and boundaries.
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		assessor from social services)			
Reed & Hocking (2013)	New Zealand	6 Occupational therapists	Action research	Explore ways for senior Occupational therapists to disseminate new knowledge, ideas and concepts to transform and re-vision practice.	Understanding of newly revised theoretical frameworks increased, and ideas were generated on how to disseminate new knowledge. Individual and group strategies were generated that could lead to change in their organization, supervising staff and changing service delivery. Co-researchers gained confidence from this process. This study supports the use of action research methodology.
Robertson & Blaga (2013)	New Zealand	70 Occupational therapists	Cross-sectional survey (part of a larger study)	Identify assessments used by acute care Occupational therapists, their purpose, and the role of occupational therapy home visits and use of standardized tests	This study found that the occupational therapists routinely used informal methods of assessment (i.e. interviews and observations) to evaluate ADLs, and to find out information about the patients' home environment, cognition, transferring, leisure, and upper limb function. However, cognitive assessments and home visits were employed when there were questions about safety in discharging. Standardized assessments were

Robertson & Finlay (2007)	United Kingdom	9 acute care Occupational therapists	hermeneutic phenomenological study	Exploration of the lived experience and meaning of practice for acute care Occupational therapists	<p>rarely used except in cases where the therapist wanted to confirm cognitive status.</p> <p>Three themes emerged: making a difference, gaining strength from the team, and coping strategies. Providing equipment was rewarding. Relationships with team members provided both a sense of satisfaction and also stress, but being a member of the team helped the occupational therapists cope with difficult situations. Coping strategies also included acknowledging the realities of practice, including their limited power or influence in discharge planning, or when they had to be pragmatic rather than patient centered. The occupational therapists felt pride and enjoyed what they were doing and felt they were making a difference. Therapists want to do more but at times are prevented due to heavy caseloads.</p>
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Shepperd, Lannin, Clemson, McCluskey, Cameron, & Barras (2013)	United States	24 RCT studies	Cochrane Systemic Review	Review of discharge planning studies in relation to mortality, readmission, hospital costs, and improved patient outcomes	Individualized discharge plans may reduce hospital length of stay and readmission rates of older patients. However, it remains uncertain how discharge planning impacts on mortality, health outcomes and health care costs. This review provide evidence to support the use of individualized discharge plans, as they resulted in shorter hospital stays ($p = 0.0052$), reduced readmission rates (RR 0.82), and increased patient satisfaction ($p < 0.05$).
Smith, Fields, & Fernandez (2010)	United States	762 discharges by 40 PTs.	Retrospective study	Examination of the accuracy and appropriateness of PT discharge recommendations	Mismatch status between the PTs discharge recommendation and the patient's actual discharge disposition was calculated on 3 different levels: match, mismatch with services lacking, or mismatch with different services. They found that PT recommendations were implemented 83% of the time. Patients were almost 3 times more likely to be readmitted if there was a mismatch with services lacking, as compared

to a match. This study provided evidence that PTs can make accurate and appropriate discharge recommendations.					
Stein, Bettger, Sicklick, Hedeman, Magdon-Ismail, & Schwamm (2015)	United States	736 patients with ischemic and hemorrhagic stroke from 22 hospitals within the Northeast Cerebrovascular Consortium	Prospective pilot study. Assessments used included the NIHSS, mRankin, Barthel Index, Short Portable Mental Status Questionnaire . Outcome measure was the discharge disposition setting.	Study the use of a standardized assessment in helping to predict rehabilitation needs and referrals to rehabilitation after acute stroke.	Looked at predictions for discharge home vs inpatient rehab, and then IRF vs SNF. Higher BI scores (85-100) only measure associated with discharge home rather than inpatient rehab ($p<0.001$). Selection of IRF versus SNF appears to be influenced either by unmeasured clinical characteristics of individuals with stroke or by non-clinical factors, such as cost, geography, referral relationships, or IRF availability. Discharge to IRF less likely for older patients ($p<0.001$) or those patients with a pre-stroke disability/premorbidity disability ($p<0.004$).
Thomas (2011)	United States	409 Occupational therapists who work with patients with upper extremity contracture	Non-experimental cross sectional survey (information	Exploration of how pragmatic reasoning influences the decisions of Occupational therapists in dealing with upper extremity contractures.	Pragmatic reasoning aspects of personal and physical contexts can have an effect on the selection of interventions but not necessarily be a constraint. For the interventions of static

(excluding burn therapists)

was gathered from participants at one point in time.)

progressive splinting, serial casting, electrical stimulation, and positioning in addressing upper extremity contracture there was a strong association between belief in effectiveness, skill level and the likelihood of selecting these interventions ($p < 0.01$). Although in terms of static splinting ($p > 0.01$) and stretching/passive range of motion (PROM) ($p = 0.00$), the relationship between belief in efficacy, skill level and likelihood of selecting these interventions was not supported. Most clinicians employ static splinting and/or stretching/PROM even though they do not necessarily believe in its efficacy for managing contracture. Focus of study was on pragmatic reasoning, but did demonstrate how Schell's Ecological Model of Professional Reasoning's concepts of personal and practice contexts can be applied in research.

Wilding (2011)	Australia	15 acute care occupational therapists	Participatory action research (PAR)	Exploration of acute care Occupational therapists' descriptions of their profession and recognition of their contributions in the acute care setting	The occupational therapy profession is still misunderstood and not respected as it should be. May be due to actions on the part of Occupational therapists with their conformist, self-limiting and passive behavior (which does not help to promote the profession). The co-researchers in this study took actions to make their practice more occupation focused, which increased their confidence and professional esteem. The researcher suggested that occupational therapists need to question their taken for granted attitudes towards the dominance of the medical model, and reflect on how their own attitudes and behaviors can advance the profession's image and representation. This study described 2 action research cycles.
Wilding, Curtin, & Whiteford (2012)	Australia	3 occupational therapy academicians and 25 clinicians	Action research based on the book <i>Enabling</i>	Occupational therapists reflect on their practice. Aim to expand on Wilding's work and form	Two main themes emerged: promotion of scholarship, and promoting professional confidence, passion and cohesion. This study improved

Occupation II
by Townsend
and Polatajko
(2008)

community of practice
scholars across Australia.

participants' confidence and helped them think more critically about their practice and methods to improve it. Participants thinking, reflecting and discussing is an effective strategy to update their knowledge and skills and to improve their understanding of occupational therapy. Communities of practice scholars has the potential of providing professional development opportunities, increased professional satisfaction and feelings of support. Despite some of the challenges of timing, logistics, technical challenges, and online etiquette, this study validated action research as a method of occupational therapy research and the forming/sustaining of a community of practice.

Wilding &
Whiteford
(2007)

Australia

10 acute care
occupational
therapists

PAR

Exploration of
occupational therapy
everyday practices in
acute care, and how
Occupational therapists
explain acute care

Themes included:
epistemological tensions
associated with working in
acute care, antagonistic
reasoning processes, over-
inclusive descriptions of

				occupational therapy and what underlies their descriptions	practice, and challenges in communication. Occupational therapists practicing in acute care have difficulty engaging in occupation based practice and difficulty in defining and describing what occupational therapy is. Researchers propose this may be due to conflict with professional focus on occupation while practicing in a biomedical setting, however through reflection and a supportive community of practice, significant changes in practice can occur.
Wilding & Whiteford (2008)	Australia	11 acute care Occupational therapists	PAR	Evaluation of the implemented action plan (changing language) from researchers' previous study	Changing language and descriptions of their practice from a focus on function to occupation, increased co-researchers level of confidence, professional identity and empowerment within their organizations. Making small changes in language can lead to transformations in practice and promote occupational therapy's contributions.

This study further exemplifies how action research can as a research method can help generate knowledge and change for Occupational therapists practicing in the acute care setting.

Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh (2011)	Hong Kong	41 experienced health care professionals (9 physicians, 13 nurses, 6 Occupational therapists, 5 PTs, and 8 medical social workers)	Qualitative study – focus groups	Examination of hospital health care providers' perceptions of the quality of the discharge planning process, and identification of barriers to effective discharge planning.	In the Hong Kong medical system there is no standardized discharge planning or a policy driven approach. Potential barriers included lack of standardized policy-driven discharge planning, lack of communication and coordination among the different health care professionals. Recommendations for improvement included a multidisciplinary approach with clearly identified roles of the various health care professionals, improvement in health care professionals' communication, and knowledge/awareness of patients' psychosocial needs.
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Chapter 3: Methodology Research Design and Methodology

This chapter describes the action research process used in this study including the rationale and appropriateness of this methodology, how threats were addressed, the role of the researcher, and the strengths and weaknesses of action research. Also included are the participant criteria for inclusion in the study and recruitment strategies, data collection procedures, and method of data analysis. The aim of this study was to explore how acute care occupational therapists describe their role in discharge planning, what guides their discharge decisions and recommendations, how they define optimal discharge planning, and what actions or steps they can take to optimize their discharge planning skills within the current health care system.

Rationale

Action research was selected as it is a qualitative method that can be used to study the complex process of discharge planning from the perspectives of therapists who actually engage in the process. Morrison and Lilford (2001) illustrated this when they noted, “there is no understanding a...situation without understanding how the participants see things” (Morrison & Lilford, 2001, p. 443). In contrast to a strictly controlled research environment, action research can generate new knowledge and deeper understandings of discharge planning within the context of a therapist’s actual practice setting. In action research, it is the intended beneficiaries of the research who determine its direction and content; thereby, increasing the likelihood that any solutions generated will meet their identified needs (Morrison & Lilford, 2011).

Even if therapists work in a rigid system like acute care and cannot change the length of shortened hospital stays, they can still improve practice by strengthening their critical reasoning skills through collaboration and reflection on professional values, assumptions, and theories that guide practice (Mattingly & Gillette, 1991). Action research is also an approach that is highly effective in narrowing the gap between theory and practice (Glasson, Chang, & Bidewell, 2008).

Specific Procedures

In action research, a group with common interests discuss an issue or issues of interest to the group. They identify a problem area and then collectively come up with a solution to the problem. They implement the agreed upon strategy and then reconvene to evaluate the effectiveness of that strategy. If the problem remains unresolved, a new strategy is proposed and the cycle continues until the problem is resolved to the satisfaction of the group (Stringer, 2014).

In this study, two groups of acute care occupational therapists gathered online to discuss issues surrounding discharge planning practices. Several strategies were proposed, implemented at their facilities, and then the group reconvened to discuss and evaluate the efficacy of the implemented strategies. The specific data collection methods that were used are discussed below.

There is no set or natural end point to action research as during the course of action research new realities emerge that can perpetuate the study (Meyer, 1993; Stringer, 2014). However, when there is a sense that significant accomplishment has taken place, participants can choose to *stand back* ending the study. According to Morton-Cooper (2000), an action research study is terminated when it comes to a natural

end, when little more of value emerges (what she refers to as *saturation*), or when there is “co-researcher fatigue” (p. 93).

Although action research can continue into perpetuity, the researcher of the present study chose to conclude the study after a maximum of five online audio chats. This decision was made so that participation in the study did not become onerous to the participants. In actuality, the study was terminated at the conclusion of Chat 5 for Group 1 and Chat 4 for Group 2, as the data generated appeared to be sufficient in addressing the research questions of the study, and little more of value emerged so that saturation was reached.

Strengths and Weaknesses of Design

A strength of action research is that it can lead to improved outcomes, system changes, and the development of best practice guidelines. Action research also has the potential to empower participants, which may lead to increased confidence and self-esteem for occupational therapists working in a hierarchical medical model system. Action research provides opportunities for participants to reflect on their own clinical practices, take action to address any identified problems, and then evaluate the efficacy of actions taken (Wilding, 2011). Therefore, occupational therapists working in acute care may be in a better position than an external researcher to judge if observed changes in their practices are effective.

However, there are also disadvantages to action research. For example, in action research the focus of the study can change as a consequence of the action plan. One of the tenets of action research is flexibility in which the content and direction of the research is not predetermined or known at the outset (Morrison & Lilford, 2001). In addition, there is

a subjective meaning aspect to action research where “those directly implicated in the problem being researched...must be allowed to determine the content, direction, and measures of success of a research project” (Morrison & Lilford, 2001, p. 439). Therefore, the researcher may end up relinquishing control as the path of the research can become diverted from the researcher’s original or intended goal. In addressing this issue, the researcher would occasionally pose questions that refocused participants on the research questions.

In many respects, the path the researcher hoped this study would take differed from what was originally envisioned. For example, the researcher had anticipated that the groups would come up with tools to better determine discharge recommendations. This was based on the assumption that other acute care occupational therapists had the same need for more accurate discharge planning tools and strategies. However, study participants’ issues did not solely focus on the process of making discharge recommendations, but focused more predominantly on communicating their recommendations to other stakeholders.

Another disadvantage is that reflection and reflexivity are strong components of action research and are highly subjective, so that research results are situational and context specific (Morrison & Lilford, 2001). As a result, there is no generalizability to other populations as the outcomes of action research or its study results can only be applied to those involved in the particular study or the specific setting (Stringer, 2014). Furthermore, no matter how promising the outcome, the findings from action research may not translate to meaningful or sustained change.

Participants

The initial goal was to recruit eight to 12 participants for this study, so in the event of attrition, the chances would be increased that at least six participants would remain for the duration of the study. Nine participants signed and returned the informed consent form (see Appendix A) and participated in the initial online audio chat. However, by the end of the study only five participants remained in the first group. A second group was later recruited which consisted of five participants, making the total number of participants for this study 10 people. There is no ideal or accepted number of participants for action research listed in the literature (Herr & Anderson, 2005; Hughes, 2008; Pitney & Parker, 2009; Stringer, 2014). In the various articles reviewed, the number of participants ranged widely from a few participants to several hundred (Du Toit, Wilkinson, & Adam, 2010; Glasson et al., 2006; Paterson et al., 2007; Petersson et al., 2009; Soh et al., 2011). According to Kemmis (1997), action research can even involve a single person trying to enact small changes.

Although there is no typical number of participants, action research does have some components similar to a focus group, and the ideal number for focus groups is six to 12 participants (American Statistical Association, 1997; Crabtree & Miller, 1999; Grbich, 1999; Morgan, 1997). There is precedent for smaller groups in occupational therapy action research literature. Wilding and Whiteford (2008) conducted an action research study that consisted of two smaller groups of five to six participants, which they felt was preferable to a larger group of 11 participants as it afforded greater opportunity for all participants to engage in the discussion.

Inclusion Criteria

Inclusion criteria for this study were as follows:

- Full and part time licensed occupational therapists.
- Currently working in adult acute care within the United States.
- At least 3 years of adult acute care experience.

Experienced therapists were desirable as they are more likely to have a comprehensive and holistic approach to discharge planning (Crennan & MacRae, 2010; Holm & Mu, 2012).

Exclusion Criteria

The exclusion criteria were:

- Pro re nata (PRN) and contract therapists as they would have had difficulty implementing an action plan and observing outcomes, because they frequently move between different hospitals or different work settings.
- Occupational therapy assistants and aides (COTA, OTA, and aides) were also excluded as they are not licensed to perform certain functions (e.g., evaluations) that can influence discharge recommendations.

Characteristics

Initial recruitment included two males and 12 females; however, by the end of the study only females remained. There was one respondent from Alaska who seemed very interested in participating in this study and contacted the researcher several times, but never returned the informed consent; therefore, was not included in the study. The majority of participants were located in the state of Georgia, with the following states also represented: Massachusetts, Ohio, Tennessee, Arizona, Washington State, and

California. Table 3.1 displays the characteristics of each participant as well as the group each participated in.

The highest frequency of occupational therapy educational level for the majority of participants was an undergraduate degree (57%), followed by a master's degree (28.5% - 7.14% entry level, 21.43% post entry). The average number of years practicing occupational therapy was approximately four years, with a range of 3.5 to 37 years of experience, and the average number of years practicing in the acute care setting was approximately 13 years, ranging from 3 to 32 years of experience. Approximately 85% of participants were employed full time in acute care, and 15% part time at the time of the study. One participant dropped out of the study midway, as she changed her employment status from full time to PRN, and no longer met the inclusion criteria.

Table 3.1

Participant Information

Group	Participant	Pseudonym	State	Gender	Highest level of occupational therapy education	Number of years as an occupational therapist	Number of years practicing as an occupational therapist in acute care	Employment status	Remained through study conclusion	Completed exit survey	Member check
1	1	Janet	OH	F	BA	30	12 currently + 3 in the 1980s	Full time	Yes	Yes	Yes
1	2	Mary	TN	F	Other (participant did not elaborate)	13	12	Full time	Yes	Yes	Yes
1	3	Dougie Hamilton	MA	M	MA/MS post entry	3.5	3.5	Full time	No – repeatedly stated would attend next scheduled online chats but did not. No reason provided.	No	No-did not receive response to email request for member check

1	4	Felix	GA	F	BA	14	11	Full time	Yes	Yes	Yes
1	5	ICU	AZ	F	BA	27	14	Full time	Yes	Yes	Yes
1	6	Bookworm	GA	F	MA/MS entry level	19	17	Full time	No – dropped out citing work conflict. Was not included in total number of participants who completed the study, as only attended the first and last chats. The participant contacted me ahead of time stating she wanted to be an observer and would not be contributing any data to	No	Yes

									the last chat.		
1	7	Mark Smith	OH	M	MA/MS post entry	34	24	Full time	No – dropped out stating work/family conflict	No	No - did not receive response to email request for member check
1	8	Tesla	CA	F	BA	13	11	Full time	Yes	Yes	Yes
1	9	Buttercup	WA	F	BA	37	3	Full time	No – self-selected out mid-study, as no longer met inclusion criteria (went from working FT to PRN)	No	Yes
2	10	Marie	GA	F	BA	36	32	Part time	Yes	Yes	Yes
2	11	Lizzie	GA	F	Other (participant did not elaborate)	20	7	Full time	Yes	Yes	Yes

2	12	Bulldog mom	GA	F	BA	35	17	Part time	Yes	Yes	No - two email requests sent for member check, however did not receive response
2	13	Andy	GA	F	MA/MS post entry	25	15	Full time	Yes	Yes	No - two email requests sent for member check, however did not receive response
2	14	InOT	GA	F	BA	26	4	Part time	Yes	No	Yes

Recruitment Procedure

Participant recruitment initially consisted of a general invitation posted on AOTA's OT Connections Acute Care and Research forums. The next method employed was contacting all 50 occupational therapy state associations and asking them to post an email invitation to their Listserv, or to include an ad in their state newsletter. Only 10 states were willing to publish the researcher's invitation to participate in this study (Arizona, Georgia, Maryland, Massachusetts, Nevada, New Mexico, New York, Ohio, Texas, and Vermont). Several state organizations suggested the researcher contact them in several months as they were in the process of redoing their websites and email membership lists. The researcher did not take advantage of one state's offer to sell her a copy of their membership list. One other state (Montana) also informed the researcher that they only support study recruitment for members of their own state.

Recruitment for the second group also included postings to AOTA's OT Connections; however, this time the response was extremely poor. In order to improve recruitment for a second group, the researcher asked occupational therapy colleagues in other states to request their occupational therapy associations post the recruitment invitation. The researcher also posted a recruitment invitation to the Georgia Occupational Therapy Association Listserv (the researcher's home state), and letters were sent out to Georgia hospitals with rehabilitation departments that included occupational therapy services and included the researcher's previous place of employment (see Appendix B). The researcher elected not to send out recruitment letters to occupational therapy departments in other states or all acute care occupational therapists due to the unwieldy volume that might have generated.

Ethical Considerations and Review

Ethical concerns were addressed through submission of an application to Nova Southeastern University's institutional review board (IRB). No participants were recruited prior to IRB approval, and all participants were required to sign and return an informed consent form (see Appendix A). IRB application protocol #10301216Exp.was submitted and approved after successful completion of the researcher's dissertation proposal defense by her committee. The initial IRB application was approved on January 16, 2013, and a renewal application was approved on December 4, 2013 for calendar year 2014.

The informed consent process began by dialoging with potential participants during the recruitment process through phone calls and emails. An explanation of the purpose of the study and a description of all procedures and issues related to potential risks, benefits, confidentiality, and privacy were reviewed. Participants were all informed they had the right to refuse or withdraw from the study at any point. Each participant was sent a copy of the informed consent (Appendix A), to be completed before the study was initiated. Included with the informed consent was a self-addressed stamped envelope in which participants returned to the researcher a copy of the informed consent once signed. A copy of the executed informed consent was then mailed or scanned, and then emailed back to the participant for his or her files.

The informed consent stated that all information generated from this study would be kept confidential and anonymous. All material created during the course of this study was kept on the researcher's private home computer, and in a secure and locked cabinet in the researcher's private home office. All audio chats were recorded and saved

on a password protected home computer. GoToMeeting, the company used to convene the groups and make the recordings, does not archive any audio or video recordings.

In addition, to ensure confidentiality and anonymity, participants were instructed to choose a pseudonym that was used throughout the course of this study. Refer to Table 3.1 for a list of participant pseudonyms. The researcher was the only one who had access to participants' true identities. Along with a copy of the audio recordings, transcriptions of recordings were stored electronically on the researcher's private home password protected computer for later data analysis. All recordings and transcriptions were kept for 36 months from the end of the study. The recordings were destroyed after that time by shredding copies of any paper notes, and deleting all online files.

Potential harm and benefits. Before initiation of an action research study there is no way to determine with any certainty the risk of participation (Herr & Anderson, 2005). For example, true informed consent cannot be achieved in action research as the type of change and its effects are unknown at the beginning of any study (Morrison & Robertson, 2016). However, it is incumbent upon the primary researcher to use sound professional judgment in anticipating and minimizing all potential risks to subjects (Herr & Anderson, 2005).

Risks for this study in terms of loss of privacy, breach of confidentiality, or emotional distress were minimized, and no harm or adverse events were anticipated or reported during the course of this study. However, this study did involve a moderate time commitment in filling out the online surveys and participation in the audio chats. There was also no financial gain; however, participants may have benefited from participation

in this study through the implementation of action plans that had the potential to improve clinical practice and patient outcomes in their own practice settings.

In addition, the *Occupational Therapy Code of Ethics* (AOTA, 2015), and occupational therapy professional behaviors were supported throughout the study (AOTA, 2008). For example, after participants signed the informed consent, they were provided with a list of guidelines and etiquette for participation in the study (see Appendix C). As facilitator of the group, the researcher planned on addressing unprofessional behaviors by discreetly and privately contacting any offenders. However, there was no occasion to take action as none of the participants engaged in any unprofessional or disrespectful behavior. There was also no occasion to ask anyone to leave the group.

Another risk that can be encountered in relation to the action research change process is that it can be unpredictable and uncomfortable for some participants. The researcher notified participants that she was available to provide emotional support and would make every effort to assist participants who found participation in this study difficult or stressful. The researcher was never contacted by any of the participants in this study with any issues relating to discomfort or stress. In addition, as stated in the informed consent and in the general guidelines for this study, participants were informed they had the right to withdraw from the study at any point and for any reason, with the researcher maintaining the participant's privacy.

Health Insurance Portability and Accountability Act. The Health Insurance Portability and Accountability Act (commonly known as HIPPA) compliance did not appear to be applicable to this study, because there was no involvement of participants'

personal health information. In addition, no identifiable client or institution information (i.e., through case studies or therapy narratives) was revealed during the course of this study.

Study Setting

This study was conducted predominantly online; however, on a few occasions participants participated through telephone conference calling when they were unable to access the audio chat online. Study participation also included filling out several online surveys (refer to Appendix D for initial occupational therapy questionnaire, Appendix E for exit survey, and Appendix F for evaluation of selected strategies).

Instruments and Measures

This was a qualitative study. The online instrumentation as methods of data collection and equipment used are discussed in the Data Collection Procedures section below.

Reliability and Validity of Measures

Threats to trustworthiness encountered in this study included researcher bias and issues of subjectivity, confidentiality, and ethics. In addition, incorrect interpretation of data may have been a threat. Ethical issues and threats to confidentiality are addressed in the Ethical Considerations and Review section of this chapter.

Trustworthiness. In qualitative research, threats to trustworthiness are addressed through the strategies of credibility, dependability, transferability, and confirmability (Pitney & Parker, 2009; Stringer, 2014).

Credibility. Credibility is a reflection of what occurred during the study and its relationship to the study's believability and integrity. According to Stringer (2014),

credibility is supported through prolonged engagement in which participants have an opportunity to examine the issue of interest. This study's audio chats were similar to focus groups, and "focus groups should provide all participants with extended opportunities to explore and express their experience of the...issues related to the problem investigated" (Stringer, 2014, p. 92).

The credibility of action research is strengthened by having multiple methods of data collection (Morrison & Robertson, 2016). Other credibility strategies included in this study were triangulation and member checking. Triangulation was supported through multiple sources of information including participant online surveys and peer review (material from this study was reviewed by acute care occupational therapy colleagues). Member check was addressed during the course of the study by paraphrasing what the researcher heard participants say during the online audio chats, and then asking the group to validate what the researcher was hearing was actually what was being said. Member checking also included having participants review the categories and themes that emerged from the study and commenting on them. This opportunity was extended to all participants, even those who dropped out of the study before its conclusion. Refer to Table 3.1 for a list of participants who provided feedback.

Feedback from member check and peer review are reviewed in Chapter 4 and were incorporated into changes made in categories and themes during the data analysis process. Credibility was also supported through acknowledgement of the researcher's biases in reflexive journaling, and description of research procedures and decisions made. The researcher's bias statement is included below.

Transferability. Action research is context specific so the results may be transferable but cannot be generalized. Transferability refers to the potential of applying the results of a study to a similar practice context. The results of this study are not generalizable but may be transferable, meaning they can be beneficial and applicable to other occupational therapists working in acute care and may help inform their discharge planning practices. For example, several participants asked about sharing the group's action plans with coworkers, and also stated that some coworkers expressed an interest in participating in some of the action plans.

Dependability. Dependability refers to transparency and clear articulation of research procedures including the study methodology described in this chapter.

Confirmability. Confirmability is a reflection that the study and procedures actually occurred as described. This can be accomplished through an audit trail including review of the study data, and researcher journaling and notes describing the study sessions and data analysis evolution. These notes were incorporated into the final draft of categories and themes and study findings.

Researcher bias statement. Researchers often have a *pre-understanding* and have assumptions about the phenomenon of interest (Coghlan & Casey, 2001). As a 59-year-old woman with over 30 years of general occupational therapy experience including 15 years working in acute care, the researcher brought to this research study her own experience, attitudes, and opinions about acute care occupational therapy discharge planning practices. The researcher's last place of employment as a clinician was at a large teaching hospital where she was employed for 8 and one-half years. However, the

researcher also had experience working at smaller community hospitals, home health, skilled nursing facilities, long-term acute care, and acute rehabilitation facilities.

The researcher felt confident and competent in her professional reasoning and discharge decision making skills for routine discharges, and felt her recommendations were generally respected by other team members. However, the researcher often felt uncertain and anxious about discharge planning for the more complex patient (i.e., due to living situation, insurance coverage, and level of support/supervision needed), diagnoses whose prognosis she was uncertain of, when her recommendations were in conflict with other disciplines, or those patients she had limited information about or minimal time to interact with.

The researcher's interest in this research topic was spurred by her search to find additional tools to improve her own discharge planning skills and abilities. The researcher had a preconceived idea of the direction she had hoped this research study would follow including the development of best practice guidelines for discharge planning, or discovering which standardized assessments acute care clinicians were currently using to help determine the most appropriate discharge disposition. The researcher's basic aim was to find out what other acute care clinicians were doing, if their struggles and challenges were similar to hers, and which successful strategies they employed that she could incorporate into her own practice.

Role of the action researcher. The researcher in action research promotes dialogue between all participants and provides an environment that facilitates observation, reflection, and transformation through the action research cycle (Soltis-Jarrett, 1997). As such, the role of the researcher in action research can be described as

one of facilitator, consultant, advisor, and resource person (Lofman, Pelkonen, & Pietila, 2004; Stringer, 2014). However, according to the literature there are different roles or positions of power that an action researcher can assume. The person conducting the research is typically thought of as either an insider or an outsider action researcher. An insider is someone who tries to enact change within their own place of employment or community. An outsider is someone who is brought in from outside the community as a consultant to facilitate stakeholder change. In participatory action research, the insider action researcher has the dual role of being both a researcher and a participant in the study (Roth, Sandberg, & Svensson, 2004). The level of involvement for an insider action researcher can range from peripheral and objective, to complete immersion and a more equitable distribution of power with the other participants (Roth et al., 2004).

The primary researcher of this action research study was neither an insider nor an outsider. The researcher was not sharing or entering anyone's work environment or hospital setting. This study was not considered participatory action research with the researcher's role as a co-participant; all those involved in this study (researcher and participants) practiced in different hospital settings with different external factors (e.g., different reimbursement sources, populations, and geographic areas). In order to minimize bias, the researcher's role in this study was one of facilitator only.

The purpose of action research is not just to solve an identified problem but also to create knowledge and develop new understandings of a phenomenon. With the researcher's role limited to facilitator and not co-participant, she assumed it would be easier to be more objective and more open to other participants' ideas and opinions. However, in order to gain a greater understanding of the experiences of the

participants, the researcher engaged in some of the same strategies selected by the first group (as discussed in Chapter 4). However, the researcher no longer belonged to the same community of practice as the group participants (i.e., acute care occupational therapy) as during the course of this study she changed practice settings.

Data Collection Procedures Used

A collaborative process was used to identify issues surrounding discharge planning and strategies to implement in addressing issues. In order to facilitate this collaborative process, an online format was selected for the ease and convenience of participants and the researcher. As there is no set format for action research, an online approach appeared to be a cost- and time-efficient method. Online instrumentation included surveys, audio chats, and researcher journaling.

Surveys

In this study all participants were asked to fill out a short online questionnaire through SurveyMonkey (<https://www.surveymonkey.com/>). The purpose of the questionnaire was to collect demographic information, level of experience, attitudes, and opinions about occupational therapy discharge planning practices, and to obtain information for audio chat scheduling purposes. The questionnaire consisted of multiple choice questions, rankings in order of importance, and short essay questions (see Appendix D). At the conclusion of the study, participants were also asked to fill out an exit survey reflecting on whether and how their discharge planning skills and practices had been transformed through participation in this study.

Online Audio Chat

All audio chats were recorded and later transcribed for data analysis. The online audio chats were considered the primary source of data. Each online audio chat lasted approximately one hour. An online chat had the advantage that it generated data from multiple perspectives and obtained consensus from multiple participants in the same amount of time as a one-on-one interview with an individual. An online chat also appeared more economical than renting a room or audio and visual equipment.

The format of the first audio chats for both groups included review of the purpose of the study, general guidelines, group discussion of what effective discharge planning is, barriers often encountered, and lastly through consensus, the selection of a single strategy to be implemented by each participant of the group when they returned to his or her own individual facility. A list of the selected strategies or action plans used in this study can be found in Appendix G.

The format of subsequent audio chats included a group evaluation of the selected strategy, consensus on its effectiveness, and whether further action needed to be taken. This cycle was repeated until the conclusion of the study. Audio recordings were transcribed by the researcher and a reputable transcription company. The researcher had elected to transcribe the audio recordings as it was more cost effective and would allow her to listen to recordings to see if the impressions she initially formed were accurate. Nonetheless, for the last 80 minutes of recordings a transcription company was used due to a malfunction with the researcher's home computer.

Researcher Journaling

The researcher kept an online journal of her impressions, how she felt the study was progressing, including issues and challenges, and how she addressed them. This was a form of audit trail of decisions and actions taken. Journaling provided the opportunity for the researcher to examine her values, beliefs, and assumptions about discharge planning in acute care. It also allowed her to reflect on her own performance and critical reasoning skills in forming discharge recommendations.

Data Analysis

Data were analyzed using Stringer's (2014) sequential method that included reviewing the data, unitizing the data, coding and categorizing, identifying themes, and organizing a category system. According to Stringer the first step of reviewing the data involves reading of transcripts with a focus on familiarization with expressed ideas and viewpoints, and making decisions about which data is important to include for analysis, and what would be irrelevant. The researcher read over all transcripts first in order to familiarize herself with the data. The data was then reread concentrating on expressed ideas and viewpoints deemed important for analysis including issues related to the focus of the study and research questions.

The next step of unitizing the data involved going through the relevant data and identifying units of meaning, which are discrete concepts, experiences, words, or phrases related to the focus of the study. In categorizing and coding, each unit of meaning was separated into a category labeled for identification of a certain aspect of the data. In identifying themes, categories and subcategories that were developed were further examined for any common or unifying themes. In the final step of organizing a

category system, the themes were recorded showing a clearer view of how they are all related to the focus of the study. Analysis was continuously refined throughout this process with each repeated and progressive review of the data, categorizing, and coding. Adjustments were additionally made based on feedback from member check and peer review, as discussed in Chapter 4.

Assumptions and Limitations of Methods

The main assumption of action research methodology is that change is possible. There is also the assumption that participants, as a group, can identify a problem, agree on a strategy, implement it, and have the ability to evaluate its efficacy. The researcher's assumption underlying the selection of this method was that although there are many things outside occupational therapists' control when it comes to discharge planning, there are also many things within occupational therapists' power to change. In addition, any changes undertaken would be sustainable and would support optimal discharge planning; ultimately, leading to better and more client-centered patient outcomes. An additional assumption was that participation in this study would shed more light on and generate a deeper understanding of the experiences of acute care occupational therapists in the discharge planning process, resulting in participant professional growth and feelings of empowerment.

A limitation of this method of research is that often there is no natural end as the action research process involves an iterative spiral of reflection, action, and evaluation. The maximum number of online audio chats for this study was set at five, so only a limited number of ideas were generated and strategies tried during the course of

this study. Additional meetings may have generated additional strategies (e.g., best practice guidelines for occupational therapy discharge planning).

Another limitation is not knowing if sustained change occurred as no follow-up contact was scheduled as part of this study. There was also heavy reliance on technology (Internet), which at times did not work properly. This method also relies on the sustained *buy in* and continued interest of participants, and is also highly dependent on the skill level of the facilitator in asking probing questions, and guiding the group in achieving consensus.

Summary

This chapter describes the action research methodology used in this study, its rationale, issues related to rigor (through methods of triangulation, member checking, peer review, researcher journaling, and transparency of research procedures), and the various procedures involved including recruitment, data collection, and data analysis. This also included a description of participant characteristics including inclusion and exclusion criteria.

Two small groups of experienced occupational therapists currently practicing in acute care with at least 3 years of experience were recruited. Data collection methods included participation in several online audio chats examining discharge planning practices, and ways to improve the process through action planning. In addition, participants were asked to fill out an initial and exit surveys as additional means of data collection. Stringer's (2014) sequential method of reviewing the data, unitizing the data, coding and categorizing, identifying themes, and organizing a category system was used for data analysis. The relative strengths and weakness of action research as the selected

methodology for this study were also discussed, as well as any ethical considerations involved in this study (i.e., confidentiality, informed consent, discussion of potential harm or benefits, and the IRB application).

Chapter 4: Results

As part of acute care occupational therapy practice, therapists routinely make judgments about the need for continued occupational therapy, resources, or modifications that patients will need after discharge. Along with safety, the goal is to provide opportunities for patients to reach their full rehabilitation potential and achieve their highest level of independence. Having a poor discharge plan can have a detrimental effect on patients' quality of life, emotional, social, mental and physical functioning, often leaving patients with unmet needs and caregivers with an increased burden of care (Bauer et al., 2009; McKelvy, 2004; Mistiaen et al., 2007).

This study aimed to address the following research questions: (a) How do acute care occupational therapists describe their role in the discharge planning process? (b) What guides acute care occupational therapists discharge decisions and recommendations? (c) How do acute care occupational therapists define optimal discharge planning? and (d) What actions can acute care occupational therapists take to optimize the effectiveness of their discharge planning skills within the current health care system? For occupational therapists, discharge planning involves consideration of client factors, support systems, financial resources, insurance coverage, hospital policies, as well as use of the knowledge, skills, expertise, and professional reasoning. In this chapter, the researcher reports on the results of this study including key issues for occupational therapists as contributors to the discharge plan. It also includes exploration of factors

related to discharge decision making, action plans generated, and themes that emerged from the data.

In discussing the findings, quotes attributed to participants are listed by the participant's assigned number (1-14) as shown in Table 3.1, Chapter 3. After listening to the audio chats for transcription purposes, it was not always possible to identify the voice of all speakers, especially if they did not identify themselves when speaking. In those instances, quotes that cannot be attributed to a specific person are listed merely as *participant*, and not with an identifier number.

For the purposes of reporting findings, all quotes are identified by which group they belonged to (G1 or G2), the audio chat session (C1-C5), and the line(s) number where the quote can be found in the transcription. All data from audio chats were analyzed despite a number of participants dropping out and spotty attendance by some participants (see Table 3.1). It was felt that despite the limited contributions of these participants, their data was still valuable and therefore should still be included. Two participants dropped out citing work or family time conflicts, one participant self-selected out after no longer meeting the inclusion criteria of working full or part time, and a fourth participant did not attend any chats after participating in the initial chat, and did not provide a reason for not returning. Member check feedback opportunities were provided to all participants, even those who dropped out of the study (refer to Chapter 3).

Data Analysis Results

This study examined the discharge planning practices of acute care occupational therapists, and the actions that could be taken to strengthen their practice. Data collected from the audio chat transcripts, notes, and survey responses were analyzed and grouped

into codes and categories based on Stringer's (2014) action research sequential data analysis and interpretation methodology as described in Chapter 3. Data fell into four general categories as follows: (a) community of practice, (b) factors that guided occupational therapy discharge planning, (c) communication, and (d) action plans. Table 4.1 lists the research questions and related categories and themes.

Table 4.1

Research Questions and Related Categories and Themes

Research question	Category	Subcategories	Associated themes
How do acute care occupational therapists describe their role in the discharge planning process?	Communities of practice	Professionalism Realities of practice Issues of respect and awareness	Role of occupational therapy Complexity of discharge planning Pragmatics of practice Why don't they pay attention
What guides acute care occupational therapists discharge decisions and recommendations?	Factors that guide discharge planning	Internal factors External factors Assessments	Complexity of discharge planning Pragmatics of practice
How do acute care occupational therapists define optimal discharge planning?	Communication	Consensus, collaboration and communication	Importance of stakeholder communication
What actions can acute care occupational therapists take to optimize the effectiveness of their discharge planning skills within the current health care system?	Action plans	Visibility Communication Accuracy of recommendations	Why don't they pay attention Importance of stakeholder communication The role of occupational therapy

Categories

The category of *communities of practice* was related to the first research question and included subcategories of professionalism in discharge planning, realities of practice, and issues of respect and awareness. Themes that emerged and that were associated with this category and subcategories were (a) the role of occupational therapy, (b) the complexity of discharge planning, (c) pragmatics of practice, and (d) why don't they pay attention. The second category of *factors that guide occupational therapy discharge recommendations* included subcategories of internal factors, external factors, and assessments, and was related to the second research question and themes of complexity of discharge planning and pragmatics of practice. The third category *communication* related to the third research question and included the subcategory of consensus, collaboration, and communication, and was related to the theme of importance of stakeholder communication. The last category of *action plans* was related to the fourth research question, and included the subcategories of visibility, communication, and accuracy of recommendations, and was related to the themes of why don't they pay attention, importance of stakeholder communication, and the role of occupational therapy.

The results of the data analysis are discussed in the following sections and are organized by each of the four research questions. Under each research question, data is presented as it related to an associated category and subcategories including discussion of identified issues of concern related to discharge planning with supportive participant quotes.

Research Question 1: How do Acute Care Occupational Therapists Describe Their Role in the Discharge Planning Process?

The data collected in relation to this question reflected a community of practice focus. A review of the units of meaning from the data revealed participants' views on their role in the discharge planning process, their sense of professionalism, discussion of the challenges and realities of practice in this setting, and issues of respect and awareness of occupational therapists as contributors to the discharge planning process. The researcher viewed these as elements of a community of practice where participants shared commonalities in beliefs and attitudes about acute care practice. Participants also seemed happy to have the opportunity of networking with other practitioners with shared concerns. For example, Participant 1 felt "it's nice talking to so many people who are all doing acute care...there's a need [for networking among acute care occupational therapists]" (G1, C4, L2-4). There was an overall sense from participants' responses that they shared common challenges practicing in acute care, but were gratified to know they were not alone in their perceptions and beliefs.

Communities of practice refers to a group of people in a shared domain with shared expertise, passion, and interests, who engage in collective learning through activities and discussion in finding creative solutions to improve performance issues (Wenger & Snyder, 2000). There are usually three elements to a community of practice—(a) the shared domain, (b) the community, and (c) the practice (Wenger, 2013). In this context, the participants in this study share the *domain* of the acute care setting. The *community* involves active participation in discussion, knowledge sharing, and learning from each other, which the participants engaged in during the course of this study and the

action research process. *Practice* refers to the shared practice of participants (as clinicians) who share their resources with the common interest of exploring and improving discharge planning practices within the acute care setting.

Professionalism in discharge planning. Participants' sense of professionalism included their views on the role of occupational therapy, which was reflected in their response to questions on the initial questionnaire and exit survey, and through discussion in the online audio chats. Participants saw their role as being patient advocates, supporters of a holistic outlook, and being members of an interdisciplinary team with the ultimate goal of facilitating client-centered discharge recommendations. Participants also saw their role as assessing past, present, and future needs of their patients including predictions of recovery and levels of support needed. This included recommending reasonable and feasible plans to help achieve patient optimal functional independence including (a) recommendations for durable medical equipment, (b) home modifications, (c) further services outside the hospital, (d) providers of patient and family education, (e) listening to the patient, (f) assessing safety risks, and (g) providing supportive documentation. Additional terms used were *gatekeeper* and *triage*. Although collaboration and communication were mentioned in the initial questionnaire, there was a greater emphasis on occupational therapy 's role in communication and documentation in the exit survey.

Participants also implied that they see their role as not just predictors of their clients' rehabilitation needs after discharge, but also as advocates making sure their patients received needed services. According to Participant 1,

I feel very strongly about acute care is that we're sort of the starting point and if

we don't really advocate that our patients get OT [occupational therapy] at the next level of care, they're done, they won't see an OT [occupational therapist].

You know you can't really count on PT [physical therapist] or nursing to see that they get home health OT [occupational therapy] or SNF [skilled nursing facility] OT [occupational therapy]. (G1, C4, L337-340)

Participants also seemed proud of their professionalism where in many cases they would go above and beyond what was required. For example, many of the participants stated they often took the extra step of contacting case managers or social workers, physicians, and home health agencies to make sure that their patients received home health occupational therapy services after discharge.

Participant 5 relayed a story that highlighted occupational therapy's concern for patient safety and how occupational therapy input led to a more appropriate discharge plan, stating

We actually have this situation right now at our hospital...[the patient] was scheduled to go home two days ago and I went in and did the evaluation, and I said he needs at the least 24/7 supervision because he had no insight to how he was going to use that walker. He was getting up and pulling the walker to him or pulling himself up to the walker...and of course it made him lose balance the way he was trying to use it...he stood at the toilet and he wasn't close enough, had no awareness that he was urinating on himself and had a puddle on the floor at the time he left, and to have that of awareness of hygiene all of those things fall into that, you know [be]cause you can have skin breakdown as well as the fall risk. So that definitely hits home and we've been able to keep this patient in-house for a

couple more days and the discharge planner now is attempting to get SNF [skilled nursing facility] placement rather than discharge home. (G1, C3, L309-324)

Participants also felt that as professionals, occupational therapists ask the questions needed to be asked, but which are often overlooked by the other disciplines. For example, occupational therapists are able to get at the heart of essential information more than other disciplines, as their focus is more on context in terms of safety and function. According to Participant 2, “I’m the one telling the PT that the patient may have 15 steps to climb... to get into their house, so...just by our nature of questions that we ask...we find out more information than any of the other disciplines” (G1, C1, L234-236). In another example of occupational therapy’s role in obtaining key information for effective discharge planning, Participant 3 remarked,

I personally don’t feel that there’s another profession that’s going, besides maybe physical therapy, that’s going to look truly at prior level of function the way we do. I can’t tell you how many times I see it incorrectly listed by nursing, physicians, or case managers, so I don’t think they look into the details that we do, you know as far as what a patient needs to be able to do to return home. So pretty much whenever a patient is not able to give me an accurate or reliable pre-functional, pre-hospitalization functional status we’re always contacting that nursing home or perhaps family members to clarify that information. (G1, C1, L226-232)

Realities of practice. Participants felt that the discharge planning process was further complicated and challenging as it must be undertaken within the confines of the current United States health care system. Pragmatic issues included issues related to time

(i.e., short hospital stays and limited patient therapist interaction) and organization (i.e., productivity expectations), as well as changing patient presentations.

Time based issues. Many of the issues voiced by the participants related to time-based issues. These included (a) timeliness of consults including last minute consults, (b) limited time to spend with patients making it more difficult to formulate appropriate discharge recommendations, and (c) short hospital stays where therapists were limited in how much they were able to accomplish or be of benefit to their patients. In addition, time based issues in acute care are often multi-factorial, as the time of day a patient is seen, the duration and frequency of occupational therapy visits, and the client's hospital length of stay, largely determines the quantity and at times the quality of therapy services. The amount of therapy a patient receives before discharge can be an important factor in determining the ultimate discharge disposition.

Short hospital stays. Short hospital lengths of stay also created challenges to therapists' discharge decision making. According to Participant 8, "it's just the nature of acute care that in our environment it's very short length of stay and we just need to try and stay nimble to address that" (G1, C1, L81-83). However, a comment from Participant 7 highlighted the difficulty in progressing patients when the length of stay in acute care was typically short. Participant 7 stated,

Just trying to make accurate predictions when our length of stay continues to drop. You know every year it seems like we have half a day less to work with our patients, and trying to predict where they'll be in that day, and if we have another day to work with them...we can get them to change. (G1, C1, L69-72)

Another consequence of the short length of stay is that discharge recommendations usually need to be made at the time of the initial occupational therapy visit. According to Participant 11, “I’ve always learned that the discharge recommendations are done the day of admission, we have to think about where they are going as soon as we get in there and evaluate them, because they have such a short time” (G2, C1, L231-233). According to Participant 4, “you gotta know pretty much that day if they were going home, if they were leaving the hospital today where would they go. So...probably the most difficult thing is gathering all the pertinent information in a timely manner” (G1, C5, L373-375).

Another time-related issue expressed by the participants with more years of experience in the group was that provision of occupational therapy services in acute care has changed over the years. For example, years ago patients spent a longer amount of time in the hospital, so therapists had more time to do evaluations, work with their patients, and more of a basis on which to determine discharge recommendations.

You know years ago a stroke would have stayed six weeks in rehab and you had a week to do an evaluation. Now, both in rehab and acute care you only have less than 24 hours...in your 30-minute eval you got to make that decision on where is this person going and what do they need. (Participant 10, G2, C4, L472-475)

That really probably makes acute care different than everything else too, because nobody else has to decide that [discharge recommendation] within 24 hours. I mean even in sub-acute, you don’t have to decide that because they are going to be there for a good 6-8 weeks. (Participant 11, G2, C4, L484-487)

Another consequence of hospital short lengths of stay expressed by Participant 11, “is that sometimes we may see them on Friday and we come back on Monday and they’re gone, and who knows how that decision was made” (G2, C1, L241-242).

Limited patient-therapist time. Another consequence of short lengths of stay is therapists often having limited time to interact with patients. This is often due to time conflicts with other services, tests, procedures, patients not feeling well, medical instability, therapist caseloads, or a myriad of other reasons that therapists cannot work with the patient at the time that they visit.

Limited available or quality time with patients is often a factor of therapists’ caseloads and the focus on productivity. Another complication is that even if the evaluation is completed, therapists may not have the time to see patients again for actual treatment. According to Participant 12, having additional opportunities to interact with the patient was often the exception, “It just seems like we’re worrying more now about evaluation than treat, and if we get to see them again it’s a bonus” (G2, C1, L250-251). Participant 4 also described the limited patient-therapist interaction time explaining that “I look at it as a butterfly lighting on a flower...I go in and I sprinkle my little fairy dust and say this is what OT thinks, and then I have to go on to the next one” (G1, C1, L272-274). According to Participant 10,

You don’t always get to see every patient every day, unfortunately because of the caseload and you know patients having procedures, and tests, and whatnot. So sometimes we have to go back and do a follow up visit to make sure that the status hasn’t changed, since the last time that we saw them...It’s pretty much just part of business as usual. (G2, C1, L225-227, 229)

Participant 13 was in agreement that the limited time therapists actually see patients was often a barrier to discharge planning, as they needed to base their discharge recommendations on the only information that they had from the initial evaluation.

I agree that we don't get to see them every day and sometimes in our only evaluation...we don't get as much information to make our discharge recommendations, and then it being a large hospital where I am, it's sometimes hard to go back to the patient, which I feel is a barrier for me for discharge recommendations in acute care. (Participant 13, G2, C1, L237-240)

Participants also expressed frustration over having limited time to spend with patients because of large caseloads, being short staffed, and having productivity requirements. As stated by Participant 4, "you've got treatments of patients that aren't being seen every day because of the new referrals" (G1, C1, L271-272), and "I find it's very frustrating that acute care just has not offered that opportunity and it doesn't seem to be getting any better as far as patient to therapist ratio" (G1, C1, L280-282).

Because therapists often cannot see everyone on their list every day, they often have to prioritize who gets to be seen. According to Participant 5, "at this time I'm the only staff occupational therapist and I have 15 orders waiting for me in the morning...so having difficulty prioritizing, knowing which ones might...benefit from a discharge recommendation from OT is difficult to determine" (G1, C1, L36-38). According to Participant 12, caseload issues are often exacerbated by inappropriate orders from physicians, which adds to the constant balancing act of prioritizing and juggling caseloads with productivity requirements.

The people we're getting are just so acutely ill that I mean you need to be seeing,

but you kind of have to allot your time appropriately because there's other people on the floor that need to be seen too, and it's a huge balancing act... We try and see them every day if we can, but that's not the real world. You know evaluations take priority, from there you try and see your patients, and if you can't see them one day you'll try and see them the next or whatever, and then they're gone for testing, and the huge balancing act that we keep here basically. (Participant 12, G2, C3, L37-43)

I'm glad the doctors know we're here and it's wonderful...but sometimes we'll get orders on someone who is totally bed bound and has been that way for years, and it's like why are you ordering OT...its really frustrating because when you're short staffed and you gotta be careful about who you see, what time you're seeing people. (Participant 12, G2, C3, L2-5, 7-8)

According to Participant 13, educating the physicians has helped somewhat in making sure orders were more appropriate, and when to order occupational therapy services. "Literally we have these conversations about if somebody is sick give them the time to get better from the sickness before you order OT or PT, because if somebody had a UTI, they're going to get better" (G2, C3, L139-140).

Time constraints related to productivity. According to Participant 4, it was also a challenge to gather all the information needed to make a discharge recommendation when productivity expectations incentivized therapists to minimize the amount of time spent on evaluations. Participants also felt that therapists wanted to be able to participate in team meetings (which included discussion of discharge planning), but it was a time issue that had to be weighed against productivity expectations. According to Participant 5, "we've

tried such meetings [team rounds], but fell apart [be]cause people [were] not making time and such emphasis on productivity” (G1, C5, L452-453).

All the participants felt that although productivity was a huge issue relating to their performance as a hospital employee, it was also a factor of time available for provision of care. Participant 9 felt that occupational therapists spend more time than other services getting to know their patients, which helps in making discharge recommendations. However, this puts occupational therapists at an unfair disadvantage in terms of productivity. “Another thing that is [a] difficulty of me is being compared with PT in terms of productivity because I spend more time gathering info before I see the patient than the PTs” (Participant 9, G1, C1, L358-359).

Other time issues. Even the time of day a patient is seen can influence the discharge recommendation, and may account for the differences in discharge recommendations between different services. “It might be that I saw a patient in the morning and PT in the afternoon and there may be very different presentations when we saw them” (Participant 12, G2, C1, L276-277). According to two participants,

Patients do change very quickly and those discharge recommendations sometimes are in flux... There are so many variables, so...might be the time of the day I saw them...Within one day to another they may change that much. You know if a patient is progressing better, maybe they need to go somewhere else. (Participant 12, G2, C1, L261-262, L316-319)

See how maybe the evaluation of the person that you saw wasn't the same as the person who was seen in the afternoon, you know like Bulldog mom [Participant 12] said. So my evaluation may be was shorter so I...wouldn't have

done a full assessment as I could have, because maybe the patient wasn't feeling good, so that PT or the speech therapist comes and they see somebody totally different, and then make this recommendation because the patient had changed.

(Participant 11, G2, C1, L326-330)

Participants also talked about the *end-of-week* mentality where case managers rushed to discharge patients before the weekend; yet, occupational therapists felt this was often a mistake as it would increase the likelihood of patients being readmitted after the weekend. According to Participant 2,

There's this big flurry push to get people out , and I feel like if that boulder's rolling down the hill there's not too much I can do, but I really think that they need to, for the more complex people I think they should think 57 times before sending them to a facility on a weekend, because if they think we're not optimally staffed you know you get to a nursing home on a Friday evening, you're almost begging for them to be back by Sunday morning, and I just think there's this end of the week mentality and it's not always in the patient's best interests and I think therapy can see that and PT also...and it's like well the nursing home said they'd take them and the doctor says they're stable, and it's like hmmm. (G1, C4, L205-213)

On the other hand, participants also discussed situations in which patients could not be discharged because the social worker was unable to locate a facility willing to accept the patient. These patients had to stay in the hospital longer, even though they were ready for discharge as it was an issue of placement and not medical instability. Although therapy continued to work with these patients, they did not receive the same

level of therapy that the patient would have received at a rehabilitation setting.

Participants stated that priority was reserved for patients who were more recently admitted and had more acute needs, so the therapy frequency for the patients who could not be placed were decreased.

Issues of respect and awareness. As members of a community of practice of acute care clinicians, Participants shared their experiences and engaged in discussion on how occupational therapy was viewed and valued, and how to improve occupational therapy's standing within the domain of acute care. Participants were vocal about what they perceived as a lack of respect and awareness of occupational therapy's contributions to the discharge planning process. This was reflected in their concerns about (a) last minute occupational therapy consults; (b) issues with those responsible for discharge planning; (c) their perception of occupational therapy documentation not being read; (d) physical therapy recommendations having greater weight than occupational therapy recommendations; and (e) ambulation deemed a more important determinant of discharge disposition than performance level of functional activities (i.e., safe engagement in ADLs).

Last minute occupational therapy consults. One of the greatest areas of frustration expressed by participants was the lateness of consultations for occupational therapy, so that therapists did not have enough time to engage with patients before needing to make a discharge recommendation. For example, according to Participant 4, "probably the hardest thing is we get consulted late, and maybe there's not a sufficient amount of time to make really good recommendations before the patient is discharged" (G1, C1, L15-16). In addition to late consults, participants were upset that discharge

dispositions were set before occupational therapy was consulted. As Participant 9 stated, “late consults when social work and PT have already planned for the disposition, before OT has a chance to give their discharge recommendations” (G1, C1, L23-24). Participant 2 was in agreement that the timing of consults and discharge dispositions being set before occupational therapy was consulted were problematic. As she stated,

Yes, I’m agreeing with everybody else, it seems like in our department in our hospital, we’re getting consulted at the 11th hour and they need our evaluation for the patient to get into some type of facility, and so they might have been in the hospital for 30 days, and on that 30th day they’re wanting the OT to come in to assess, just to get the notes to transfer. So whatever recommendation is at that point is kind of moot because they’ve already decided on [what] the discharge plan is going to be, even if we don’t agree with that discharge plan. (G1, C1, L74-79)

You know, if I go in and evaluate and maybe I didn’t recommend what they’ve already set up, then you know whatever I recommended is just a waste of time essentially. (G1, C5, L464-465)

Issues with discharge planners. Case managers were predominantly seen by participants as the person responsible for discharge planning, and who were considered more the problem than physicians. As one participant stated, “if it’s truly discharge planning it’s usually the case managers that tell me ‘oh well I got the PT referral I’m fine you don’t have to worry about it’ So they’re more my issue than the physicians” (G1, C1, L607-608). Participant 2 was also in agreement but felt that part of the problem may be attributed to there being more physical therapists than occupational

therapists in the field, as she stated “there’s an army of PTs, and then there’s a small battalion of occupational therapists” (G1, C3, L153-154). Participant 9 described her issues as the inflexibility and disregard by some case manager for occupational therapy recommendations, as follows:

I also agree with the concern about everybody else already having the discharge plan made out, because I have had case managers make comments to me after I’ve done my evaluation to the effect of “well now what do you want me to do? We have this all figured out and now you’re telling me it can’t happen. Can you just hold off on your note”? You know those kinds of things. (G1, C2, L129-133)

Participant 2 felt that even if occupational therapy consults were necessary for discharge placement (e.g., acceptance into a rehabilitation facility), occupational therapy recommendations were often moot as the discharge plan was already decided upon by the physician and case manager. Occupational therapists were put in the position of appearing as obstructionists even though occupational therapists based their recommendations on what they believed would best meet the patient’s needs while ensuring a safe discharge. Participant 2 stated,

What we struggle with at the hospital that I work at is the timeliness of when we’re getting consulted, and it seems like the doctors and the case managers have already come up with a clear discharge plan before they are even consulting us. So when we come in to recommend something we’re almost seen as the person that makes the discharge plan change, so sometimes I don’t know if they’re...avoiding us because they think that we’re going to change it...or they’re just needing OT because the nursing home requires it, or the insurance requires it.

(G1, C2, L96-101)

One participant also brought up that she was asked by the social worker not to designate what type of rehabilitation she thought the patient needed, but to just write in *rehab* under the recommendation section. The social worker explained that it would free her up to find a place that would accept the patient, and if it was contrary to the recommendation that the occupational therapy had listed it would be seen as a conflict. Another participant stated that at one point she was told not to list her discharge recommendation but to leave it blank so that the inpatient rehabilitation evaluator could list their recommendation in the chart instead. This was seen as bypassing the occupational therapist's recommendation and professional judgment.

According to Participant 1's experience, the problem may be that others do not recognize occupational therapy's more holistic approach of thinking beyond and predicting future needs after discharge, while other disciplines may not. Participant 1 stated,

The truth is I can't trust them [case manager] to follow up, and it's a very very important situation like a broken arm that only an OTs going to deal with. This lady had no trouble walking, she's not going to get PT...Everybody's in a big rush and really their focus is different than our focus. They want to know if you have a POA [power of attorney]...if you have a ride home...but nobody's...asking the therapist are they physically ready to get into a car, get out of a car and get into the house. (G1, C5, L413-422)

Participant 1 also relayed another story about an encounter with a case manager who felt that the assistive device that the occupational therapist was recommending was not necessary as the patient could walk. However, as Participant 1 pointed out

He's a huge huge huge fall risk...and...yes it's appropriate for him to have a rollator when he goes out in the community...She's [case manager] seeing he gets up and walks fine, so why does he need this thing. They're not thinking outside of the hospital that they're seeing him in. And he could trip on a sidewalk crack real easily, and be in [the] ICU and the state would be paying for him. (G1, C5, L480-485)

Occupational therapy documentation not being read. One of the main issues for participants was not related to their skills in discharge decision making, but rather other stakeholders not seeking out occupational therapy discharge recommendations or reading occupational therapy documentation. According to Participant 8, “I mean don’t keep it a secret. It’s not like you write it down and you expect somebody to read it...because maybe they will, but most likely they won’t” (G1, C1, L502-504).

Participant 9 also expressed some of this frustration when she stated,

We can document till the cows come home but the documentation is seldom read, and so it tends to get this urban lore going through the nursing and discharge coordinating staff that everything is fine, and then if we disagree we have to track somebody down and tell them and be very pointed. Whereas perhaps a physician had he or she been able to or taken the time to read what occupational therapists write, they would not make such rash decisions. (G1, C2, L232-237)

Participant 13 stressed that it is an ongoing battle educating others to look at occupational therapy notes and recommendations:

Being a big hospital it's sometimes hard to find the physician or...case manager to make our recommendations known. So that's my biggest frustration...I feel many a times I have a full evaluation I have a recommendation, please look at it.
(G2, C1, L371-373)

According to Participant 12, "I educate all the time. I mean this is never ending, I've been doing this for 25 years and it's just of more of a challenge" (G2, C3, L54-55).

Another participant also felt that the discharge recommendations of other disciplines were based on information that was too narrow, discounting the broad and holistic approach that occupational therapy takes:

In our setting our PTs aren't as acutely aware of specific home goals and safety issues to the extent that my documentation can help provide, and so we're trying to educate the social workers and discharge planners on that situation. (Participant 5, G1, C1, L39-42)

Some participants felt this was also related to the issue of respect, as discharge planners did not fully value what occupational therapy brings to the table, as opposed to what physical therapy brings. For example, Participant 1 stated,

I don't feel I'm recognized, I mean I've been there for 12 years. I think people know who the occupational therapists are, but it's like are they ordering us appropriately...I think especially with the orthopedic population the PT eval "oh they're fine, they don't need you," and I'll go in there and there's plenty of things they need OT for. But they're just seeing a joint, and a transfer, and gait. (G1, C1,

L394-397)

Precedence of physical therapy recommendations. The lateness of orders for occupational therapy consults and the disinterest in occupational therapy discharge recommendations were interpreted by participants as disrespect for occupational therapy, in contrast to the respect shown for physical therapy. All participants expressed the same frustration that occupational therapy discharge recommendations appeared secondary to physical therapy. This perception was based on physical therapy usually being consulted before occupational therapy, physical therapy discharge recommendations being sought out and not occupational therapy, or physical therapy recommendations given more weight or having precedence over occupational therapy recommendations. According to Participant 13 it was systemic, “it’s still the norm that PT just has more weightage and I do hear myself say many a time, who’s going to look at our notes, nobody. I don’t know why we’re writing it” (G2, C3, L544-546). Participant 5 also expressed frustration asking,

How often do you guys get the same statement of patient can go home if it’s okay with PT? I just had a situation this morning where...our PTA [physical therapy aide] came back to grab the PT that he was being told that this patient, as long as it was okay with PT, this patient could go home. There are tons of patients they’ve had a TIA [transient ischemic attack]...and both speech and I have [been] working with him. I’ve seen the patient three times, PT did the initial eval three days ago, and they’re saying it’s PT that’s determining whether they can go home. (G1, C4, L 155-160)

According to Participant 12, “for discharge recommendations especially for some of the skilled nursing facilities that’s their request, that the patient has to be evaluated by the PT, and so it’s just kind of frustrating that we expend all that energy” (G2, C5, L553-555). Participants 6 and 7 both felt that by not accessing occupational therapy recommendations, patients may be discharged home with unmet needs or put at risk. According to Participant 6,

Sometimes I feel like they don’t take me seriously and I’ve had to call...the social workers...and say look, I know you want to send this person home but I don’t feel that they’re safe. So I would love for people to respect OT as much as PT. (G1, C1, L 18-21)

Participant 8 felt the focus on physical therapy recommendations was directly related to policies set by insurance companies. As she stated, “the insurers that’s always a problem that they oftentimes look at the PT evaluation to be able to accept the patient and it’s something that we have to fight really hard against” (G1, C1, L15-16). Participant 8 also felt that even if occupational therapy evaluated the patient first, the discharge planners would often state that they needed the physical therapy discharge recommendations before setting the discharge disposition. She also found that a health maintenance organization (commonly referred to as HMO) in her state only required physical therapy documentation and not occupational therapy:

There’s one HMO here, and we still get the order for referral and it’s still a consideration, and it’s not very likely that PT and OT will be that worlds apart, but this particular insurance company wants to make sure that it’s the PT recommendations that are important and transmitted. It’s a problem here in

California. (Participant 8, G1, C2, L 45-47)

Participant 7 commented that some physicians did not understand the difference between occupational therapy and physical therapy, and attributed occupational therapy discharge recommendations to patients who had not yet even been seen by occupational therapy services.

You see someone for OT and make our recommendation and the insurer will come back, and then even though it can be 100% obvious this patient cannot go home and needs...some type of continued therapy intervention, the insurer will request the physical therapy evaluation... that's my biggest pet peeves of what goes on, just the lack of respect for OT. It happens amongst our team management staff, the physicians walking through notes where OT and PT recommended "X" skilled care for discharge, and maybe we haven't seen them yet from OT.

(Participant 7, G1, C1, L 62-68)

Ambulation versus function. Despite occupational therapy's holistic approach, most of the participants felt that in discharge planning there was too great an emphasis on ambulation and too little weight on functional abilities and safety. Several common stories were related about how a discharge plan was put in place for a patient to return home based on physical therapy recommendations. However, based on the occupational therapy's observations of the patient's transfers and questionable safety awareness, the patients were clearly at risk to fall. The occupational therapists felt obligated to communicate with the stakeholders and advocated for what they believed was the better discharge disposition. Participant 1 expressed the frustration of the other participants as listening to PT before OT that is the key thing because in their minds. It's like if

they can walk to the bathroom all is well, and there's more to life than walking to the bathroom...I finally said to him [the rehabilitation director] isn't getting dressed and going to the bathroom and taking a shower isn't that what you do before you start your day? I mean they think these patients have nothing to worry about but going to the bathroom. (G1, C1, L96-100)

Participant 12 was in agreement, stating that "they default to the PT evaluation, they're hardwired...to look at how far they're walking, not the quality of gait, but how far they're walking and I think they might skim over us a little bit just to appease us" (G2, C3, L491-493). According to the Participant 5, occupational therapists excel in their assessment and documentation as it is more comprehensive than physical therapy because occupational therapy looks beyond ambulation. Participant 13 also felt that by focusing on ambulation, the focus was too narrow, "it's easy to walk down the hall...than to manage things for ADLs" (G2, C1, L334-335).

I think what it is...how far someone's ambulating. It needs to be a little bit more of functionally, [and] how can the patient manage. It's great that they can walk, but there is more to life than walking, and I think somehow we have to get them to understand that, to look at other things... at the holistic side of the patient. I think they are just very narrow-minded and there is a very narrow window of information they're looking at, and I think they're just trying to move patients so quickly that, you know, they're not always looking at the whole picture.

(Participant 12, G2, C3, L506-513)

Participant 9 also felt there is too great an emphasis on ambulation in deciding discharge disposition, as she stated

Doctors support the whole concept of 'if they can walk they are safe'...there seems to be an assumption that "someone" will be there to see all the 'details'.

Unfortunately, they don't refer to home health OT, just home health PT. (G1, C1, L148-149)

Participant 2 was also in agreement that there is too much emphasis on ambulation and not enough on function. She also felt that physicians have the sentiment that “well they walk they’re fine” (G1, C3, L137). She stated, “in this state if you walk, you can’t get into a nursing home. If you’re functional with gait, and... have two broken arms they will hesitate 15 times before taking you to a nursing home” (Participant 2, G1, C3, L137-141).

However, participants acknowledged that most patients and staff wanted to see patients walking, making physical therapy a popular service. For example, participants were in agreement that it was not just the other stakeholders but also patients that were more focused on ambulation than the ability to engage in ADLs. As Participant 12 stated “they’re just so focused on walking, while you’re not seeing half they world, you’re running into the walls...So it’s this forever battle” (G2, C3, L103-104). However, there are some exceptions, as a story relayed by Participant 13 where a patient who was unable to stand and participate in physical therapy, but gained benefit from working with occupational therapy, “we were able to give her a lot of satisfaction from doing things from the sitting level, that she felt she was getting a lot more from OT...it was nice to know that” (G2, C3, L114-116).

Perceptions of lack of respect were also expressed as both patient and staff not knowing the difference between physical therapy and occupational therapy, and the inability to differentiate between their services. According to Participant 12, “like with

our physicians it seems like everything in the hospital seems to be PT, and we're all PTs, not OT" (G2, C1, 92-93). She also stated "I'll tell them I'm OT and what we're doing and why we're doing it, and as soon as you say that, they'll say the PT lady is with me, and it's just like alright you want to hit the wall sometimes" (G2, C3, L56-58). Also according to Participant 12, "just as long as you're moving them and the patient's getting better, they don't care if you're OT or PT... We have to educate them on what we do and... how much we contribute to the patient's ability to progress" (G2, C1, L170-173).

Approximately one-third of the participants (Participants 10, 11, and 12 from Group 2) felt more positively about respect for occupational therapy recommendations and services than some of the other participants. Participant 12 attributed this to being a member of an interdisciplinary team, with a large occupational therapy department at her hospital,

I think we tend to have some of the same issues everyone else does where they look at the PT more... but I think overall we're respected pretty well. We've got a pretty large representation of occupational therapy in our hospital which helps.
(G2, C1, L124-128)

The other participants who were not involved in team meetings or rounds, or were less involved, expressed feelings of being less respected.

In addition, on floors where there was a close relationship between therapy and the medical staff (e.g., neurological or orthopedic services), participants felt that staff were more familiar with the differences between the services that occupational therapy and physical therapy provide. However, on the medical surgical floors, staff was less aware of the differences between services as according to Participant 13, "our presence is not as

extensive...I think a lot of [hospital] staff knows, but do the doctors know, no, they don't" (G2, C3, L73-76). Most of the participants felt that education about the differences between occupational therapy and physical therapy was a constant requirement.

Participant 12 did not seem to be as bothered by patients' inability to differentiate between occupational and physical therapy services, "I think patients are so overwhelmed what's happening to them they're [just] trying to process...They don't care who you are, they just want to get better...go home, and of course the all mighty thing they want to do is walk" (G2, C3, L98-101).

Research Question 2: What Guides Acute Care Occupational Therapists' Discharge Decisions and Recommendations?

All the participants agreed that discharge planning was a very complex process, with many internal and external factors that needed to be taken into consideration.

Factors that appeared to guide study participants' decisions and recommendations were reflected in the discussions in the online audio chats and responses to the initial questionnaire. Internal factors refer to client factors including (a) level of function and disability, (b) beliefs, (c) values, (d) wants, (e) level of family and caregiver support, (f) sociocultural factors, (g) financial resources, and (h) living situation. External factors refer to anything outside client factors or not attributed to the patient including (a) the organization (e.g., the hospital) and/or health care systems, (b) policies, and (c) reimbursement practices. The following sections reflect the internal and external factors participants considered when making discharge recommendations for their patients.

Internal factors. For participants in this study, patient related factors included the patient's age, prior and current level of function, diagnosis, prognosis, level and

availability of family support, home set up, geographic location (in terms of proximity to a rehabilitation facility or the hospital), and financial resources including insurance coverage. In addition, they considered their patients' cognitive status including competency, vision and visual perceptual skills, physical abilities, safety, balance and fall risk. Many of the factors considered can either facilitate or be a barrier to effective discharge placement. According to Participant 11,

Usually it's not the hospital. Insurance company yes. Client yes. Sometimes it's where they live, they may not have access to what's recommended as a discharge plan. Even the self-payers...not so much that they have insurance but they may not have any insurance, which can be a barrier, and the lack of not having any family could be a barrier, and their prognosis and their diagnosis. (G2, C1, L81-85)

In addition, Participant 2 stated that as an occupational therapist she looks at factors that other disciplines may not consider which helps provide support and justification for her discharge recommendations. According to Participant 2,

I'm looking at everything...I'm looking at cognition, I'm looking at the psychosocial factors, I'm looking at balance, mobility, and so I'm kind of putting together the big picture, which I feel is when I do have problems with the discharge plan, I can say well this is what I did with the patient, this is why I feel like they're not safe. (G1, C2, L200-203)

I want to know the layout of the house. I want to know whether there's a tub bench or a tub chair or a walk in. I get a lot of picky little details, whereas people just say...“Do you have a way to shower,” and they'll say “yes” or

whatever. I want more specific things. I mean that's what OT does. (G1, C3, L131-134)

Many of the factors identified during the audio chats were consistent with participants' responses to the initial questionnaire, where participants were asked to select the five most important factors they considered when making discharge recommendations, and rank them in order of importance (1 – most important; 5 – least important). Results can be found in Table 4.2. The five most important factors listed in order of importance were as follows:

1. Current ADLs and IADL performance level.
2. Patient's living situation.
3. Patient's functional level prior to admission.
4. Vision.
5. Balance.

Although being client centered is a core occupational therapy value, patients' and/or their family's wishes and preferences, came in eighth.

Table 4.2

Factors Considered When Making Discharge Recommendations

Factor	Weighted average
Current ADLs and IADL performance level	1.75
Patient's living situation (i.e., alone, with family/caregiver support...)	1.83
Patient's functional level prior to admission	1.90
Vision	2.25
Balance	2.33
The opinions of other team members involved in the discharge planning process (i.e., other disciplines' notes)	2.50
Current level of ambulation/functional mobility	2.55
Patient's (and family) wishes and preferences	2.63
Cognitive status and level of safety awareness	2.69
Current diagnosis and medical/surgical treatment	2.86

Insurance (what it covers, what it won't)	3.20
Patient's age	3.25
Use of a safety or pre-discharge screening tool or checklist	3.50

Note. Participants selected their top 5 factors considered in making discharge recommendations and ranked them in order of most important (1) to least important (5). The lower the number the greater it was ranked in terms of importance.

Adding to the complexity is difficulty in making discharge recommendations and predicting future needs when the patient's medical presentation changes, or if they are a *borderline* patient. A borderline patient was described as someone who did not wholly meet the criterion for one discharge disposition versus another, or there was uncertainty in terms of safety for returning home alone:

In acute care things can change so quickly, they can get much better or much worse quickly. So you know it's very hard to say for certain what discharge is going to be like because you're asking to assess people when they're at their absolute worst, they have tubes going in uncomfortable places, it's challenging. (Participant 1, G1, C1, L93-96)

I always worry if I have a patient, like a borderline patient it's so hard to decide if they should go home, or we all have those borderline patients that home doesn't seem safe but they are very high level for another setting. So you want just a couple of days just at the hospital, maybe that will make them more safe before they go because they are not eligible to go anywhere else. (Participant 13, G2, C1, L243-246)

Another challenge in making accurate discharge recommendations that was often cited by participants was the makeup of their caseloads, or the types of patients seen in acute care. Often patients are acutely ill especially those in the intensive care unit (ICU); however, patient presentation does change largely due to medical management. This

often makes making discharge recommendations more challenging, as the recommendation has to change as the patient's condition changes (for better or worse).

Sometimes we may evaluate a patient and may be in ICU and on Tuesday you make one recommendation and by Thursday they're well and they're ready to go home. The spontaneous and/or the medical care that they get...changes the discharge plan that you recommend. (Participant 11, G2, C1, L253-256)

I may not know what their baseline function is. Or I may not know who they live with, if they have family that's available to help after discharge. They may be too soon after surgery to really see that the swelling goes down and once they get off the pain meds and whatever, you know, how they are going to do, that kind of thing. (Participant 11, G2, C4, L137-141)

Included in internal factors related to the patient are also factors related to families and caregivers. Client centeredness is a core tenet of occupational therapy but at times this can be challenging for therapists when patients' and families' wishes conflict with what therapists believe is the best disposition for the patients. For example, Participant 10 related a story of a 95-year-old patient with advanced dementia who resided in an assisted living facility where at most she was checked on only every few hours. The patient was admitted for a fall and had a history of recurrent admissions for falls. The occupational therapist recommended a memory impairment unit at a skilled nursing facility with continuous supervision as she felt the patient was unsteady, unsafe, and therefore, at risk to fall again. However, the daughter insisted that the patient return to the assisted living facility with home health occupational and physical therapy. Participant 10 felt "at 95 with advanced dementia, you know that with all the OT and PT

in the world is not going to make her safe from falling” (G2, C4, L244-245). As the therapist felt she could not force the issue, she suggested at a minimum obtaining a chair and bed alarm, and having a sitter 24/7. The patient was discharged the next day, so the occupational therapist assumed the patient had returned to the assisted living facility but did not know if the daughter had made any extra provisions for the patient. The occupational therapist did speak with the social worker and physician about her concerns before discharge, but ultimately, it was the family member’s decision. However, the occupational therapist also documented her concerns as she felt there was nothing else she could do, as “sometimes you get overruled...by the family” (G2, C4, L253-254).

Participant 11 related another story in which a patient was dependent and the family insisted on taking him home, but it seemed to the occupational therapist that the reason why they want to take them home is for the SSI, so they can collect...even though it’s not said, you know...they really need to be in the sub-acute level for better care, but what are you going to do. (G2, C4, L265-269)

In another example as relayed by Participant 11, there was a situation where the family wanted an acute rehabilitation placement, but the patient did not qualify for that level of therapy because of her impaired cognition and limited ability to participate in therapy. "The family member [asks]...well why can’t they go to rehab don’t they need therapy? Well, they do, but they only follow 20% of commands" (G2, C4, L174-176). There was also discussion of patient or family members not wanting the patient to go to a subacute rehabilitation facility because they viewed it as a nursing home placement. In this situation, the occupational therapist educated the patients and families about the benefits of this type of rehabilitation setting. According to Participant 10,

The family situation is [also] a big one, even if they are appropriate for acute rehab they won't take them if there's no family available to care for them afterwards if they don't make it to independence. That's a big one. The finances of the family is a big one, you know if they can afford to hire somebody while they are at work or not. (G2, C1, L68-71)

In addition to factors related to the family, disposition options can be limited by how far a patient is ambulating (as a criterion for acceptance to inpatient rehabilitation), or even where the patient is agreeable to going. They are walking so many feet that it disqualifies them from a number of settings, and also to some patients, just no matter what you suggest they don't want to go to rehab, or they want to go to acute care, or they want to go home, or any arranged agreement where they want to refuse placement. (Participant 12, G2, C1, L94-97)

Therapists' experience and level of critical reasoning skills are other factors in discharge decision making. According to Participant 13,

I do have years of experience and we do have varied experienced people in our department, and I think it makes a huge difference when you have more experience and more knowledge, because if we have two to three years of experience and more, then I can see the difference in how you actually go about evaluating and treating the patient and your thoughts about discharge planning...having the experience of the outcome...you can explain to the client better, and then you know with this client this is going to work better, it's different for each client and I think with experience that counts...but for

somebody who doesn't have that much experience and has not seen the progress that much, may not be able to make the decision on where the patient should go...It also depends on how much you do with the patient in their room...to know how much they're going to progress...If you go in and you're doing bed level stuff you don't know how much they can do...if I personally see they may have potential I go beyond and I do a little more like an inpatient treat with them just to see if they can handle that, and then I make a recommendation to inpatient [rehabilitation]. (G2, C3, L377-385, 393-394, 399-404)

Participant 12 was in agreement that using her experience and professional reasoning helps her work with patients, which aids in discharge planning. She also felt that experienced therapists can see beyond the immediate needs, which helps puts things in perspective for clients. For Participant 12,

I think, [the] more experience you have, you're able to kind of cut to the chase basically, kind of predict what's going to happen with the patient based on past experience and kind of figure out what it is that might be the best for the patient treatment wise, discharge wise and so forth... I put a lot of my professional and personal judgment into things, but I also know that sometimes things that [I want to work on] the patient might not be interested in, and so if they're not interested, I'm not going to waste my time, but there are some things the patient does have to have some fundamental skills to go home [or to the] next level of care and they may not understand that, so I'll find a way to bring them to understand it or I'll kind of take the back door...and find a way of getting them to make it look like it was their own idea. (G2, C3, L408-421)

According to responses on the initial questionnaire (Appendix D) participants felt their discharge recommendations were accurate as 93% of their discharge recommendations were in line with the patients' final discharge disposition. In addition, the participants were asked to list the approximate percentages of their discharge recommendations to selected settings or programs. The most frequent discharge disposition recommended across both groups was to skilled nursing facilities, followed by home health services, and then acute inpatient rehabilitation as illustrated in Table 4.3

Percentage of Participants' Discharge Recommendations to Selected Settings and Programs (N=10)

Setting	Average percentage
Subacute rehabilitation	28
Home health	19
Acute inpatient rehabilitation	18
Home (without follow-up services)	13
Outpatient	9
Hospice	7
Long term acute care (LTAC)	6
Nursing home	3
Rehabilitation day program	2
Cardiac or pulmonary rehabilitation	1
Total	10

External factors. In addition to internal factors (related to the client, family, or therapist), participants stated that many of their decisions were based on external factors that they felt were often outside their control. These included issues such as insurance coverage, rehabilitation bed availability, or hospital policies. Therefore, participants stated they often had to modify their initial recommendations for pragmatic reasons.

Taking a pragmatic approach. Participants felt that often the recommendations they made would not be implemented because of a lack of insurance, or because patients lived far from the hospital; therefore, it was unknown if any resources were available in

the counties where patients lived. The limited number of acute rehabilitation facilities available was seen by participants as a barrier to occupational therapy discharge recommendations. For example, if a rehabilitation bed was not available, a patient would need to remain at the hospital longer, or a different discharge plan needed to be considered.

Overall, insurance coverage was seen as the largest barriers to client-centered discharge planning. For example, participants felt there was no recourse for patients who needed acute inpatient rehabilitation but could not be placed because of financial considerations. According to Participant 10,

My biggest frustration is the things that are outside of my control in terms of discharge planning, like the insurance, what they will cover, or the lack of insurance. The fact that the patients have to linger in the hospital for sometimes weeks on end until they could find a facility that's willing to take them. Those kinds of issues that I feel are more outside of my control. (G2, C1, L381-384)

Participants also expressed frustration that occupational therapy cannot be a stand-alone service for home health therapy unless physical therapy, nursing, or speech therapy first opened the case, even if the patient had significant occupational therapy needs but did not require the other services (i.e., good mobility but impaired cognition or vision). According to Participant 10, years ago they would have been seen by occupational therapy services, but no longer. Participants generally felt that this practice was unfair both to the patients and to themselves. Participants also expressed powerlessness about making system-wide changes such as health care policies or allocation of health care resource within the current system. Contacting government

representatives or lobbyists was briefly touched on, but none of the participants were open to pursuing this avenue.

Another issue identified by participants is uncertainty about the discharge itself, adding to the complexity of discharge planning. According to Participant 11, well sometimes the discharge [in acute care] isn't always for sure. Like in rehab, I mean you pretty much know that when you are in rehab, you are going to go home... but, you may not necessarily do that in acute care, that the discharge destination isn't...necessarily firm. (G2, C4, L428-429, 433-434)

In addition, therapists often did not know how long patients would remain in the hospital or their predicted length of stay at a rehabilitation center after discharge.

Participants also complained that certain discharge planners asked that they not specify the type of rehabilitation or follow-up care a patient needed, so that it would not conflict with the discharge plan that was already put in place. This essentially left therapists with no choice but to agree with what case managers had selected.

We never look at what the insurance is when we go to evaluate or for discharge recommendations. It is after we've made our discharge recommendation we may discuss it with the case manager, because she comes then to us 'okay you're recommending this but because of the insurance reasons, can we make some changes to your recommendations'. Otherwise our recommendations are based on all the aspects that we look at [for] every patient... There are some issues where the insurance is taking forever to approve the next level of care, so then we've had to change our recommendations. (Participant 13, G2, C1, L202-206, 210-211)

Participants stated that at times they recommended a certain discharge disposition, but often changed it depending on how the client progressed, or if they became aware of information they did not have initially. According to Participant 12, therapists have to be flexible based on the situation, so

I might change my recommendation depending upon the situation, if its insurance driven, you could almost dictate by it, or if it's more of a patient's decision, you know 'I don't want to go here' and you know it's in their interest to go to the next level...but I have changed my recommendations, sometimes no matter what you recommend it sometimes the place other...than you'd like them to be. (Participant 12, G2, C1, L215-219)

If they're walking more than 100 feet with contact guard, then even though they can benefit from acute care [acute inpatient rehabilitation], you know it doesn't matter because they are not going to qualify for that level of care. So then you might have to change to a subacute level if there's no family available to provide 24 hour supervision, and sometimes the PT and I will get together with the social worker and kind of hash out what's covered, what the family can provide, and those kinds of things and come up with the plan. (Participant 10, G2, C1, L281-286)

In addition, participants often felt they had to change their recommendations to fit in with the current plan that was in place, or to be in agreement with the other disciplines' recommendations. However, at other times participants stuck to their recommendations and professional judgment, despite differences with other services. Participant 12 stated "I typically don't back down from my decisions but am certainly willing to discuss things

with the team whether it's PT, speech, or whoever it might be" (G2, C1, L279-280).

According to Participant 13,

We look when the recommendations are different, then we discuss it out and see if we can change. Sometimes it just ends up that with some further recommendations we are able to come to a consensus as to where the patient should go. Otherwise...I keep my recommendation as is. I don't change it because of PT recommendations. (G2, C1, L269-273)

Assessments

Another issue brought up by the participants was the need for standardized assessments to help with discharge decision making and determining the patient's next level of care. Although not all participants were currently using standardized assessments, most participants felt there was a need to explore this area further.

Use of standardized assessments. A few participants stated they were already using standardized assessments primarily in determining cognitive status, but the assessments were not consistently administered according to their standardization. There was also discussion that at present, there is no one assessment tool currently available that addresses the diversity of patient populations found in acute care. According to Participant 1,

I think ultimately as a discipline OT needs to come up with some better tools for assessments and acute care is hard because it's such a mishmash of all kinds of stuff, and every time you read up on things usually it kind've segues back over to just strokes or just ortho joints or things that are easy to research, but that's not what my caseload is like. (G1, C4, L301-304)

Some participants found it hard to find assessments that encompassed all aspects related to discharge such as safety and equipment needs. Participant 4 also stated that having a formal assessment tool can be difficult because of the level of medical acuity of many hospital patients:

It has always been a challenge to have anything that's formalized just because of the acute care setting you've got people who are so sick they're in a hospital bed, setting things up...I've had a very hard time with that. (G1, C1, L274-276)

However, according to Participant 8 standardized assessments do have a place in occupational therapy discharge planning. She stated,

I think it would be great to have some tool to help predict what level of care is needed, and it would also give us increased credibility with all of the other powers that exist in an acute care hospital. (Participant 8, G1, C1, L110-112)

According to Participant 1, she uses the Saint Louis University Mental Status (SLUMS) Test to substantiate cognitive issues that she observes, "I can say they scored 12 and that falls within dementia range...and that's been helpful" (G1, C1, L116-117).

Several participants described assessments they currently use in their practice, but these tools were not being used according to their standardized format. Again, according to Participant 1,

They were pushing us to use the Allen [Allen Cognitive Test], but I don't like that because you're asking people to do something in a non-standardized way in bed, you know things attached to them and you're asking them to do leather lacing, and to me it just doesn't seem valid, and you know [it was] designed for able bodied psych patients is the way I envision the Allen. (G1, C1, L117-120)

Participant 8 also discussed the issue of administering assessments in unintended or incorrect ways, and how sometimes the limited information occupational therapists have about patients has to suffice in forming the basis for discharge recommendations.

For example, Participant 8 stated

If you are using standardized tests in ways that they weren't designed to use, are you using a standardized test, it's something to consider...how can you make a judgment from range of motion to discharge, but we're being asked to do that, and we need to...take what's in our brains, and put that down in some kind of structured and formatted way so that we can answer the questions in a reliable and consistent way. (G1, C1, L249-254)

Participant 6 seemed to be in agreement stating,

I definitely do a lot of functional activities completely all are ADLs, and then I also use the SLUMS so that way I have a cognitive part as well...but...sometimes I modify the SLUMS and I use it more as just another type of assessment as part of my clinical judgment and reasoning. Just so I have a little bit more standardized I guess "assessment" in quotations, to add to my assessment for the day. But I don't use it on every person. (G1, C1, L191-195)

Most of the tools discussed assessed cognition; however, several participants were primarily interested in assessments that also measure function. According to Participant 1,

I just wanted to say in terms of using a mental screening how does that give you any function, [be]cause that's what I'm always challenged to show is function. You know can they get dressed or use the equipment. Can they use the grab bars

appropriately, so that I am seeing their mental sequencing but in a functional manner, and leather lacing I haven't found translates into the function that doctors and nurses...or discharge planners are looking to understand. (G1, C1, L132-136)

With occupational therapy's focus on function, Participant 1 brought up an interesting point about what does *function* mean in the (unnatural) hospital setting. For example,

The term functional is like functional for our setting, it's not what's meaningful to them [patients]. You know the last time I took a sponge bath was 24 years ago after childbirth. It's not something that a functional activity needs do, whereas standing in a shower really washing myself is. You know things that I do in the hospital that I feel are real are when men shave themselves, or women put on makeup or do their hair. But a lot of it you know a bedside commode transfer and stuff, those are functional things that need to be done, to do function in the hospital, but they're not really [what] the people [would choose]. (Participant 1, G1, C5, L204-210)

Participant 3 felt the emphasis on assessment tools should be more on fall risk and safety but with an occupational therapy spin. According to Participant 3,

I mean I find it hard because I think a lot of patients will look into predict[ing] whether or not they will be a fall risk at home. I feel like sometimes the lines are a little bit blurred with standardized assessments for falls, kind of where...OT can be different than PT. So sometimes I have a hard time using the Tinetti where it's more of a PT based assessment. At the same time, I do want that fall risk [information]. (G1, C1, L174-177)

Participant 2 felt selected standardized assessments helped her communicate better with the physicians about patient skill level or other clinical issues. For example,

I use the Ashworth and the Modified Ashworth Scale a lot in my documentation for spasticity, and also the quick DASH for arm and shoulder pain, I use that quite a bit [G1, C5, L251]. I think with the neurologists in the hospital, they respond better when I document with Ashworth Scale as far as spasticity goes...Again the DASH is something easy to use for disability ratings, and in showing improvement. (Participant 2, G1, C5, L256-258)

Participant 1 also felt that occupational therapists delved a bit deeper to find out how their patients were managing prior to admission, looking for any subtle cognitive issues that may have been missed by others. She stated,

I don't actually write it out this way in the note but one thing I often ask them is "how do you get your groceries," because that gets a little more detail out of them than "can you get yourself something to eat." You know "where is this food coming from." You get more information if you find out where their resources are coming in, or if they are going to the store. Sometimes people are, and you didn't expect that, or they're taking their power wheelchair to the store. I mean literally down the street. (G1, C3, L229-235)

Participants brought many examples of how they informally assessed cognition while talking with patients. For example, Participant 2 talked about how she looked for red flags while talking with patients about medication safety and compliance. She stated,

I ask them about their medications. I ask is anybody setting their medications up for them, and if they say no and they're independent I ask if they're using a pill

sorter. Because a lot of them are taking them straight from the bottle, and sometimes...you [go] through teaching them [about using] a memory aid [so] there's no question of did I or didn't I take it, and there's no chance of double taking it or missing it [medication dose] as much. (G1, C3, L290-294)

Research Question 3: How do Acute Care Occupational Therapists Define Optimal Discharge Planning?

Exit survey responses to the question of *how would you describe effective or optimal acute care occupational therapy discharge planning* included meeting patients' and families' needs, and putting together a plan that best matched the patients' wishes, functional status, and environmental supports, as well as an interdisciplinary approach, thorough documentation, and daily communication between all stakeholders. Effective discharge planning should also be initiated at admission with a *whole picture* view of patients in order to best understand them and a consistent review of occupational therapy recommendations by discharge planners and case managers.

Communication

Participants felt that optimal discharge planning involved timely referrals, good communication, and conditions where all stakeholders were on the same page (e.g., patient, family, therapists, discharge planner, and third party payers), so that the patient received any and all recommended and necessary services, and with agreement on the discharge disposition. As communicated by Participant 10, in "successful discharge planning...include[s] the patient as well as family, team [members], insurer being on board to get the patient the services that best suits their needs." Table 4.4 lists participants' responses to this question but as responses to the exit survey were

anonymous, individual participants could not be matched up to their responses.

Responses are listed in chronological order.

Table 4.4

Participant Responses to the Question About Optimal Discharge Planning

Participant	Responses
1	It provides the optimal post-acute rehab to meet the patients/families' needs
2	Optimal acute care dc [discharge] planning includes communication and thorough documentation between all members of the team
3	Timely referral, sufficient documentation of pts [patients] prior functional status and discharge options, consistent review of OT recommendation by discharge planners/case managers
4	Interdisciplinary. Thinking outside the box maybe occupational therapists could arrange for physicians' orders as we see fit for equipment and post discharge therapy. Then turn it over to the formal Discharge Planners/Social Workers to do the leg work. An example from today: Fragile elderly man with COPD had to go to Pulmonary clinic exclusively to get his Home Care Nursing and PT orders renewed. He was stable per clinic documentation. Coming home in 90+ heat and humidity he collapsed on front porch and came to hospital (ICU on Bipap). Now almost a week later he is on 2L but much weaker/can barely take a few steps with PT and wheeled walker. The PT recommended he get a w/c until he can transition back to being a household ambulator. The discharge planner has made arrangements to have it delivered AFTER he returns home. I wrote a big note. I left voice mail message for Discharge Planner. Tried to phone family for the heads up-no answer. He's with a Medicare HMO so it depends on how busy and conscientious other staff are to hassle with it .My recommendation is he gets whisked home as quickly as possible via ambulette w/c service in his new wheelchair.
5	A plan that matches the patient's wishes, current functional status, and the environmental support available.
6	OT discharge planning to be effective or optimal should be initiated upon admission with interaction with the team that includes not only the OT, PT, ST, Resp. [respiratory] Therapists, discharge planner, but also the nurse, physicians, as well as patients & caregiver(s).
7	Input from EVERY team member is sought out by MD and SW either by reading notes or verbally
8	Based on PLOF (prior level of function), current level of function. Help available at home.
9	This is not an easy thing! Seems like it is always in flux. I think daily communication with the team involved with each patient. Esp[ecially] the case manager who sometimes tends not to see the "whole picture" or understand the patient best.

Consensus, Collaboration, and Communication

According to participants, an interdisciplinary approach through consensus and collaboration appeared to be key ingredients necessary to ensure an optimal discharge plan; however, good communication including documentation was cited as the most important element. For example, participants stated that the most effective strategy was taking the initiative to seek out essential stakeholders and verbally conveying the occupational therapy discharge recommendation with its underlying rationale. As Participant 8 stated, “I’m not shy about talking to anybody. I’ll call the discharge planner. I’ll call the doctor...just really communicating a lot. Telling the nurses what you’re seeing, telling the family what you’re seeing” (G1, C1, L499-502). Participant 12’s strategy was to communicate as much as she could to ensure that discharge planners understand what she was focusing on and what her recommendations were. Participant 11 added that “it definitely takes documentation, communication, and...verbal communication with the team. You just can’t make a recommendation and document it, and then disappear...We have to be an advocate for the patient, and we have to be an advocate for ourselves” (G2, C1, L287-289).

Another participant also talked about the importance of reaching out to discharge planners, suggesting

Dialogue a little more so that they feel that they can come to you, because that’s what I have found. The ones that I have actually sat down and talked with, and said you know feel free to use my pager. I’m not offended if you page me. I have a better rapport with, than the ones that just “Oh, I know what OT is” kind of thing. (G1, C1, L725-728)

According to Participant 13, ensuring good communication also entails developing relationships with discharge planners. The longer the relationship and the better the rapport with the team, then the better the communication should be. “It’s easier to go and talk to the case managers and they really listen to what I have to say and it takes going and talking to them instead of them looking at our occupational therapy documentation” (G2, C1, L151-153). Participant 13 also felt that it’s important for occupational therapists to make their presence known. Most participants felt that education was the most effective strategy to showcase occupational therapy’s contributions to discharge planning. The occupational therapists at one participant’s hospital were very proactive stating,

I’m at a teaching hospital...one of the things we do is we hit those residents on June 30th as soon as they get there, and every month when they rotate...we make sure that we spend a few minutes with them. (G1, C1, L511-513)

Participant 11 also stressed the importance of knowing the other stakeholders, who are the people that you work with and how to get in touch with them, so the best discharge plan can be put into place for the patient. For example, Participant 14 felt it was important to have good communication not just with case managers and physicians, but also with the physical therapists who are also working with your patients. The close working relationship between occupational and physical therapy was exemplified by participant 3 who stated “one of the fortunate things I see with physical and occupational therapy is that we work interchangeably, so if one person needs a safety eval to get home it’s usually one or the other” (G1, C1, L27-28).

When there were discrepancies between occupational and physical therapy recommendations, the participants advocated talking it out in order to achieve consensus. Nonetheless, there also appeared to be a dichotomy in how participants thought they were viewed or respected by other stakeholders. In some instances, participants felt their documentation and recommendations were overlooked by others in favor of physical therapy. However, because of what they perceived as the *good communication* they had with social workers and sometimes nurse practitioners they felt occupational therapy recommendations were welcomed as a starting point for discharge planning. A commonality of both study groups is that the social worker or case manager were seen as the *go to* persons in terms of discharge planning, and not the doctor. They did state physicians were generally open and amenable when they were approached by the occupational therapist.

According to Participant 3, communicating occupational therapy's contributions to other stakeholders may seem challenging but is important and doable. He recounted,

One of the things we've done in the past couple of years for OT month is speak to the hospitalist group and then case management group at staff meetings, where you just kind of do case stories that explain what OT is, so using cases that occupational therapists have been really successful in working with for discharge planning, and kind of telling our story that way. I've found that to be pretty effective. (G1, C1, L506-509)

Language. Participants felt that it was just not having direct lines of communication with discharge planners but also using language in documentation that reflects the discharge issues surrounding the patient and the unique service that

occupational therapists provide. This is one area where the language and outcomes from standardized assessments may be helpful. According to Participant 9, language is powerful and has the potential of conveying occupational therapy professional reasoning processes that underlie occupational therapy discharge recommendations. However, she felt that occupational therapists did not use the best or most descriptive language or vocabulary to convey the occupational therapy approach to discharge planning, or issues of patient safety. According to Participant 9,

I think perhaps we have the knowledge and the skill, and I know that everybody in the world likes to have numbers and concrete things that we can refer to. I wonder if it's not a matter of the way we're documenting, our documentation system, and the language that we use. Maybe we don't have the words that are needed right at the tip of our tongue, and so in that sense having those more formal assessments to refer back to gives us words to use...My experience working with occupational therapists is we know this stuff and it's the how do we communicate it to other people, and so having the language available...words that describe judgment, for example the inability to anticipate consequences...inability to project oneself past this point in time...I might describe as they're not able to remember what they were doing when the stove caught on fire, or if the doorbell rang while the stove caught on fire. (G1, C2, L271-277, 283-287)

Participant 4 also felt that occupational therapists know what they are about, and have the requisite skills and expertise to make effective discharge recommendations, but they need the language to communicate it, stating “we know what we're talking

about...it's communicating that to someone else that's sometime[s] it's a challenge, so if there's something like this that can help us I think that'd be great" (G1, C2, L361-363).

Research Question 4: What Actions can Acute Care Occupational Therapists Take to Optimize the Effectiveness of Their Discharge Planning Skills Within the Current Health Care System?

The aim of using action research in this study was to formulate, implement, and evaluate action plans in the process of addressing identified issues of concern and improving discharge planning practices. After discussion of problems and issues related to occupational therapy discharge planning, several strategies were proposed. Four action plans were implemented and evaluated by study participants.

Action Plans

The general aim of the selected action plans was to increase the visibility of occupational therapy's contributions to the discharge planning process, improve communication with those responsible for discharge planning, and encourage other team members to access occupational therapy documentation. In addition, one action plan focused on increasing the predictive ability and accuracy of discharge recommendations through the use of standardized assessments. The category of action plans included the subcategories of visibility, communication, and accuracy of discharge recommendations. However, the following sections are organized by individual action plans and not subcategories as there is some overlap in the purpose of the selected strategies.

Action Plan 1: AOTA fact sheets. The first strategy included providing case managers and physicians with AOTA fact sheets on acute care practice, and discussing with them occupational therapy's contributions to the discharge planning process. This

strategy was in response to participants' feelings that those primarily responsible for discharge planning lacked awareness of occupational therapy 's contributions to the discharge planning process. As one participant stated, “with case management [we need to] increase their knowledge of what we can actually do” (G1, C1, L626-627).

Although mixed, feedback on this strategy was predominantly positive.

According to several participants, it resulted in sustained change as it resulted in case managers reaching out more to occupational therapists for their discharge recommendations. According to Participant 4,

We had a really good experience. I basically took the fact sheet, I bought some of those OT post it notes for OT month and a bunch of candy, and we have 4 occupational therapists in acute care so we took about an hour one day, and a half an hour another day to go and visit all of our case managers in the hospital, which is 20+ case managers, and our goal was to provide the fact sheet. We also identified those questions that...this group talked about last time about the visibility and communication and the discharge planning, so we made sure that if they had any questions about what OT is, then we made sure they knew how to find our documentation, and then one of our biggest things was making sure that they understood the importance of looking at OT discharge recommendations and why as comparing PT and OT that they may be able walk, but they don't know where they are going or something like that. So, you know, I think it was very good. It definitely increased our communication, it increased our visibility. We typically have a pretty good relationship with case managers but this was a good focus because all four occupational therapists...were specifically talking about

discharge planning so I think it was very successful in our hospital. (G1, C2, L15-27)

Participant 9 also found this strategy effective, stating

I did actually find that it improved communication. A lot of people, particularly floor nurses were just really surprised at the scope of OT and just looking at two weeks prior and two weeks post, that two days that I ran around the hospital and had all these conversations, we've got a trend up of referrals. (G1, C2, L61-64)

Participant 4 also stated that she posted the AOTA fact sheet by the desks where the physicians did their dictation and documentation. She said she was approached by one of the doctors who said he wanted to let her know that he had read the whole fact sheet, so she felt it was also overall a positive strategy. However, according to Participant 2, this strategy was not effective as she stated,

I don't think things were as favorable. With the case managers at my hospital, it seems like the majority of the case managers were not entirely standoffish but just disinterested. I was trying to be energetic and incorporate some of the patients on the floors giving examples, but I can't really say that it helped much at the hospital that I work at. (G1, C2, L31-34)

Action Plan 2: G-code standardized assessments. Although the group decided that the AOTA fact sheets were helpful in increasing awareness of occupational therapy, they wanted to address the issue of standardized assessments as a way to further support occupational therapy discharge recommendations. The general feeling was that incorporation of standardized assessments would be a beneficial tool in assisting with determining predicted levels of care needed after discharge. As the study was conducted

just prior to the implementation of G-codes, and participants at that point in time were unfamiliar with the mandates of G-codes, they decided to select several standardized assessments that were G-code compatible. It was important to participants to select assessments that addressed function as they felt that is what makes occupational therapy unique. As Participant 4 stated, “I think I tend to like something that’s addressing something different than what PT might be addressing” (G1, C2, L375-376). Two other participants were also in agreement,

I...try to do something that’s different from PT. I do...functional transfers and that type of thing many times because our physical therapists aren’t seeing the same patients every day as I am...And so having something that’s more measureable...and it’s self-care directed, I think will be more practical.

(Participant 5, G1, C2, L378-382)

I’m going to agree...choosing an assessment that incorporates...self-care because even in the aspect of self-care there’s the aspect of balance when you’re testing for standing or transfers or for putting on pants etcetera. So the use of some kind of standardized assessment I think will be something good to do.

(Participant 2, G1, C2, L385-388)

The three assessments selected were the Barthel Index, Boston University's AM-PAC 6 Click ADL, and the Patient Specific Functional Scale. Of the three assessments selected and implemented, the consensus was that although they were quick and easy to implement, available free online at the time, easy to access, and no formal training was required, they were generally not helpful in treatment planning or in making meaningful discharge recommendations.

Participants felt these assessments lacked sensitivity, were too simplistic, subjective, and did not provide any additional information that the therapist would not have found out through their routine evaluation. According to Participant 1 regarding the Barthel Index, “it’s very superficial and truthfully a difference between mod assist and min assist is a huge difference in the burden of care” (G1, C4, L298-299). Participant 8 agreed, “[I] didn’t feel that it helped with treatment planning. So if you were working with a stroke patient, it didn’t give you information or standardized assessment information about treating the stroke patient or anything like that” (G1, C5, L41-43). Participant 2 also agreed, “I don’t know that it really adds any extra oomph to the discharge planning, then again it is something good that you could use maybe if you wanted to in the end show improvement in the overall functional status” (G1, C5, L60-62). Two other participants had similar issues with G-code assessments and their utility with discharge planning in acute care.

Well I did not have a successful time with trying to implement this. I found it really hard...to either ask them the questions...for the Patient Specific Function Scale or with filling out the Barthel, and I had a hard time seeing how that was really giving me anything more than I was already extrapolating from my evaluation...maybe...it was me just not taking the time to do it better or stronger...and see what I could do with it, or if it was just not conducive for acute care. (Participant 4, G1, C3, L13-19)

I guess the thing I would say too is that it’s not really conducive to acute care. I especially did not like immobile for less than 50 yards. Up to 50 yards of gait is damn functional for acute care. That will get you room to room

easy...That's somebody who can even be alone and get to what they have to do. I didn't like the showering part because [in] my hospital they don't have showers so that would be an automatic no go. I just thought it was very simplistic and I could see maybe for home care but it's just like our people get put into catheters right away, and occasional accidental bowel movement to me that's incontinence, because adults don't have occasional accidental bowel movements...I think if you wanted somebody to understand what we do just real clear clinical reasoning in the note makes more sense. (Participant 1, G1, C3, L21-37)

The issue of subjectivity was important as participants felt there could be discrepancies between what the patient reports on the forms, and what is actually observed by the occupational therapy. According to Participant 8, "there's a lot of literature out there about bias with self-report" (G1, C5, L332-333). However, Participant 8 also felt these assessments could be a good repeated measure tool to see how patients fare over time, especially with recurrent readmissions:

The Barthel it's really not the best tool for planning treatment but it's a good way...to do repeated studies because we get a lot of the same patients over and over again. So this way we have a standard way to kind of see if they've changed functional status at all over time in a very structured way. (G1, C3, L67-71)

Participant 2 also talked about the difficulty with self-report assessments, stating

A lot times if you could ask them if they could do something...they're not talking about that. They're talking about two weeks ago when they were fully independent and didn't need any help with anything. So sometimes you really have to pinpoint them down...A lot of ours are dementia...those are the ones who

feel they can do everything and a little voice in your head is going nah, I don't think so. (G1, C5, L335-347)

Participant 1 also commented on how oftentimes therapists have to simulate activities for these types of ADLs assessments, because they lack the normal conditions of the actual activity. This begs the question of whether these tests are still *standardized* and how much do they really help in making discharge recommendations. According to Participant 1,

Obviously I don't have regular clothing that they can put on over their IVs and the PICC line and all that. So what I'm doing is just kind of a clinical judgment thing that says, yes they have the sitting balance, yes they have the arm mobility, yes they're the kind of person that would get dressed in the morning, and put that they don't need help...Then some things you just take their word for it. (G1, C5, L306-310)

The participants did not find the selected assessments of this action plan helpful in improving the predictability and accuracy of discharge decision making and recommendations. In addition, at the time of this action plan the mandate for G-code reporting was expected but not yet implemented. Based on these reasons the participants decided not to pursue this action plan further.

Action Plan 3: Smart phrases. As the group decided that the assessments were not helpful and in response to the issue of discharge planners not paying attention to occupational therapy documentation, the group decided on a strategy of using more descriptive language in their documentation, the focus of the third selected strategy. This included collaboratively putting together a list of keywords, phrases, and questions which

they called *smart phrases* (refer to Appendix I) that would better highlight therapists' concerns about patient safety, and would help support and add value to their discharge recommendations.

The group consensus was that the smart phrases sheet was helpful to them in documentation and communication, especially for more complex cases and some participants shared their smart phrases with co-workers who also began to use them. Several participants saw potential in using a more descriptive language approach for stating their discharge recommendations. For example, according to several of the participants,

[To develop] a cheat sheet that was really meaningful in terms of the assessment like what items to always include that reflects how you think about the patient... 'given the context the person lives in, the demands of their environment I would recommend this', or 'the patient is a high fall risk [and] can therefore... benefit from rehab but chooses not to and has a 24 hour caregiver', or something that would highlight what is different about the way we think about a patient, which is in terms of what they have to do every day... how the environment can support them or hurt them and come up with a cheat sheet or some key words that will reflect our special thinking. (Participant 8, G1, C3, L120-128)

One of my new phrases is that I've been using a lot is especially for people that live alone and the doctors are pushing them to go home alone, and there's a concern for them being able to escape their house. I will write things like 'patient will not be able to escape house if an emergency arises' and that one

phrase that I've used on several instances has helped patients get into nursing homes, that needed to be in nursing homes a long time ago. So I don't know if between all of us as a group we could put together phrases that...stand out and helping put more value to it. (Participant 2, G1, C3, L176-184)

I do think you're on to something...if we get some fall back terms that we can sort of pepper things with that gets [them] thinking...about not being able to respond in an emergency...Sometimes if I've got a patient whose [got] some cognitive stuff going on, I would ask them what...would you do if your daughter fell in the house while she with you, and she needed to go to the hospital? And a lot of times that stumps them big time. You know some of them will say 'press my emergency button or I'd call 911', those are the answers you want. But sometimes they just give some off the wall answers. 'I'll call my son at work', and it's like what if he can't come to the phone, and they're just stumped. [They'll respond] 'so I'll wait till somebody comes'...and just a real passivity kind of thing.

(Participant 1, G1, C3, L354-362, 366-368)

Participant 2 also shared a story in which she felt her descriptive documentation, helped others better understand some of the issues her patient was dealing with. She recounted,

I took him down to the gift shop and documented what he did and what he didn't do, and a big theme was how he wasn't asking for help, and I think when you document in terms of real behavior that people can relate to, I think it painted a better picture. (G1, C4, L146-149)

According to exit survey data, participants for the most part continued to use the smart phrases even after the study was over. There was some discussion of further

developing this strategy outside of this study, and trying to enlist others to help add to the smart phrases list or come up with a list of scripts but this idea was not pursued by the group.

Action Plan 4: Highlighting recommendations. The second study group identified the same issues as the first group, but appeared more complacent and less invested in generating a list of strategies to address identified issues. Second group participants also seemed to focus more on factors they perceived as outside their control to change. As a result, only one strategy was proposed and implemented. The focus of this final strategy addressed the issue of how occupational therapy notes were written. In order to increase the visibility of occupational therapy discharge recommendations in documentation, the group elected to highlight discharge recommendations in a different color font, all in caps, all in bold, or listing it at the beginning of the note instead of at the end. Participant 12 stated that at her facility, they had successfully requested that the format of electronic documentation for occupational therapy notes be changed so that discharge recommendations would be listed at the beginning of notes. According to Participant 12,

We've reformatted ours [electronic documentation] so the first thing they read is our assessment and recommendations... it seems to me it's a little bit easier for the doctors to read, they don't want to waste time looking for something, I think it's right there and they get what they need and if they want to look for anything else in the document they can. (G2, C1, L447, 465-467)

However, the other participants felt they could not make that request at the hospitals where they worked, and that listing the discharge recommendations at the

beginning of their notes and not at the end would be odd. Feedback on highlighting, bolding or writing discharge recommendations all in caps was mixed, as participants did not employ this strategy consistently. Participants stated they tried to encourage others in their departments to adopt this practice, and although their coworkers were supportive they frequently forgot to implement this strategy. However, one participant stated that one of her coworkers always highlights his discharge recommendations and they were always noticed.

Other strategy suggestions. Additional strategies were suggested but not adopted by the group (see Appendix J). One strategy suggested by Participant 4 included making a short video on the contributions of occupational therapy in the acute care setting and to discharge planning (or locating a YouTube video) that all newly hired doctors would be mandated to watch. However, this strategy was ruled out as some participants stated they were not allowed to post any media on hospital sites. According to Participant 2, "it's against our corporate compliance that we stream videos using our computer systems, because it slows down our documentation portal, so we've been banned from all videos on the computers in our hospital" (G1, C2, L185-187).

Another proposed strategy was having family members take videos or still photos on their tablets or cell phones of the patient's home set up, and then sharing it with the occupational therapist. This was felt to be a creative strategy as acute care occupational therapists in the United States are no longer doing home visits, and it is often difficult to make recommendations for home modifications or equipment without seeing the patient's home layout first hand. Participant 5 suggested,

Have family take video pictures on their cell phone or something to be able to

come back so that we can give more concrete recommendations based on the appearance of the homes...because the discharge plan can say that we recommend a bath bench but then when you see how the bathroom is set up, there's no way that bathroom bench would fit in that environment, or we can simulate better at the hospital to determine if they'd be safe if we knew the set up better. (G1, C4, L126-131)

Participant 5 also highlighted the difficulty of trying to determine patient needs when occupational therapy cannot see the actual home environment. There are many challenges in trying to simulate the patient's home set up so patients can practice needed skills while still in the hospital. According to Participant 5, she discussed with her rehabilitation department director about the inability of occupational therapy staff to go out into the community, and relayed

As far as not having the safety issues or a safety assessment, we've been asked if we can actually go out to the home and do a home evaluation and from the acute care setting I'm being told not to do that. So trying to set up and simulate in our department is very limited because I am in the ICU unit sometimes discharging people straight from there. (G1, C1, L42-45)

Although the strategy of having family members take photographs or videos of the home environment was discussed by the group, it did not become an action plan.

Another strategy discussed but not implemented was the development of a comprehensive assessment tool for the acute care setting that would lend credibility to occupational therapy discharge recommendations. Participants felt that assessments based on objective data or scores would be more effective than simply stating "the patient is just

not safe." This strategy was not pursued as several participants felt it would be too difficult to come up with a tool unique to the domain of occupational therapy that would fit the broad diversity of patients seen in acute care. Some participants felt this type of tool was absolutely needed as the scores could help convey the language that occupational therapists want to express, while other participants questioned whether this type of tool was even necessary.

Data from the audio chats also highlighted strategies that participants were currently using in their practice to communicate their discharge recommendations and educate others about occupational therapy. These strategies included participation in team rounds and conducting little fairs in high traffic areas during occupational therapy month. A list of these strategies can be found in Appendix H.

Findings

The aim of this study was to explore what actions could be taken to optimize the effectiveness of acute care occupational therapy discharge planning practices. In order to determine what actions need to be taken or what action plan needed to be adopted, a variety of issues of concern to participants were identified and explored. Themes that emerged included the role of occupational therapy, the pragmatics of practice (in this setting), the complexity of discharge planning, why do they not pay attention (issues of respect and awareness), and the importance of stakeholder communication.

Participants appeared confident in their abilities to make discharge recommendations, so their issues did not revolve around their discharge decision making or professional reasoning skills. The primary concern seemed to be on why occupational therapy recommendations were not being sought, and the implications for patient care.

The general consensus was that participants felt there was a lack of awareness of occupational therapy contributions to the discharge planning process, as they felt that other team members did not read their notes, and therefore, were often unaware of occupational therapy recommendations or the reasons behind them. Participant 8 phrased the issue as “we should be looking at well why aren’t they paying attention...what is it, what of value do we bring to the table and how can we show that to them” (G1, C1, L713-715), or as Participant 4 pointed out, “if they know what we’re about and what we can really do for the patient, then that might solve some of these other issues we brought up” (G1, C1, L462-464). However, they all acknowledged the importance of communication with other stakeholders, and felt this was the best avenue to pursue.

In addressing the research question of *how do acute care occupational therapists describe their role in the discharge planning process*, the participants saw occupational therapy’s role as being patient advocates, educators, contributors and members of the discharge planning team, and evaluators of patient safety and future needs. In addressing the question of *what guides acute care occupational therapists discharge decisions and recommendations*, the factors that participants considered were varied and included both internal and external factors, both within and outside of their control. Internal factors related to the clients, their families, and therapists’ own experience. External factors included insurance coverage, hospital policies, criteria for acceptance at discharge disposition sites, or rehabilitation bed availability. However, pragmatic issues relating to conditions within the practice context such as time based issues and payment for services largely guided occupational therapists’ discharge decision making and recommendations.

All these factors underscored the complexity of discharge planning and the challenges of making discharge recommendations within the current health care system.

Some participants also stated they used standardized assessments or parts of assessments for further evaluation of cognitive status, but as a general practice standardized assessments were not employed. However, participants were interested in exploring this area further as to-date there is no one assessment available to assist occupational therapists with discharge decision making in the acute care setting. One participant also felt that using language in standardized assessments in documentation could help therapists convey the rationale of their discharge recommendations to other stakeholders. In addition, participants felt that occupational therapy assessment and recommendations were more comprehensive and holistic than physical therapy. However, there was too much emphasis on ambulation, at the expense of patients' abilities to safely engage in functional activities.

In response to the question of *how do acute care occupational therapists define optimal discharge planning*, it was described by participants as a situation where the patients' needs were met with all stakeholders being in agreement. Good communication and teamwork were seen as essential for this to occur. In addition, the participants felt that occupational therapy's holistic approach to patient care and discharge planning should be supported in order to ensure that patients were discharged to the appropriate setting where their needs would be met and any safety concerns would be addressed.

The participants also felt that establishing a good relationship and rapport with other team members was essential in ensuring a successful and smooth discharge or transition in care. They highlighted the importance of contacting discharge planners

directly to convey their discharge recommendations and not solely relying on others to read their notes. Despite participant's feelings there was a greater reliance on physical therapy recommendations and ambulation in discharge planning, they also felt it was important for good patient care to work closely and collaborate with physical therapy services.

The action plans were in response to the question *what actions can acute care occupational therapists take to optimize the effectiveness their discharge planning skills within the current health care system*. The purpose of each action plan was to increase the visibility of and provide support for occupational therapy discharge recommendations. All the action plans underscored the importance participants placed on enhanced communication, and emphasizing the value of occupational therapy discharge recommendations. The most successful action plans were using the AOTA fact sheets to enhance dialogue with case managers, and the use of smart phrases in documentation.

Success of an action plan was determined by the responses and number of participants who deemed an action plan successful or promising. For example, in use of AOTA fact sheets, Participant 4 stated she had a really good experience, and Participant 8 felt this action plan resulted in an increase in the number of occupational therapy consults. Participant 9 was more neutral stating that the case managers she approached with the fact sheets were already aware of the scope of occupational therapy services. Participant 2 did not feel it was effective as the majority of case workers she approached appeared disinterested.

Participant 5 felt the smart phrases were effective as she stated, "I'd say some of the phrases definitely had some pertinence especially the ones where you're trying to

describe the cognitive and safety...but definitely the safety ones for the home independence and that type of things. Those were valuable” (G1, C4, L42-47). Participant 1 stated, “I am the Smart Phrase person...it does help” (G1, C4, L72-76). According to Participant 2, “I used them several times and I think they’re very helpful and I passed them along to my staff and they thought they’re very helpful as well” (G1, C4, L113-114). Participant 4 was also in agreement stating, “I too found them helpful. I found that I used them more often with the more complex cases, so...it was...helpful and nice to have those” (G1, C4, L116-117).

Evaluation of the selected standardized assessments and highlighting discharge recommendations in documentation was not as clear cut as the other two action plans. For example, participants did not feel that using the selected assessments assisted them in making discharge recommendations, but perhaps might be useful in showing changes in function over time. Participant 2 stated she did not have good luck with the agreed upon action plan assessments, but unlike the other participants, she had additionally used the Berg Balance scale, which she found helpful in discharge decision making. Participant 4 stated “I did not have a successful time with trying to implement this” (G1, C3, L13), and Participant 1 stated, “it’s not really conducive to acute care” (G1, C3, L 22). According to Participant 9 regarding the Barthel Index, “its really not the best tool for planning treatment, but it’s a good way...to do repeated studies because we get a lot of the same patients over and over again” (G1, C3, L67-69). The fourth action plan of highlighting discharge recommendations in documentation was not adequately tested as participants did not consistently employ this practice. Table 4.5 offers a summary of predominant areas of concern identified by participants and the response of both study groups.

Table 4.5

Areas of Concern Identified by Study Participants and Action Plans Agreed Upon Through Consensus and Adopted

Associated theme	Findings	Action plans Group 1	Action plans Group 2
Pragmatics of practice	Challenges of time based issues	No action taken	No action taken
Issues of respect and awareness	Limited awareness of occupational therapy's contributions to the discharge planning process	AOTA Fact sheet to educate case managers about occupational therapy's contributions; and smart phrases	Highlighting discharge recommendations in documentation
Issues of respect and awareness	Perception of occupational therapy documentation not being read	Smart phrases	Highlighting discharge recommendations in documentation
Issues of respect and awareness	Perception of PT recommendations taking precedence over occupational therapy recommendations	AOTA Fact sheet to educate case managers about occupational therapy's contributions	No action taken
Complexity of discharge planning	Limited use of standardized assessments	G-code assessments: Barthel Index, Boston University's AM-PAC 6 Click ADL, and the Patient Specific Functional Scale (PSFS)	No action taken

Summary of Results

Through the action research process, two groups of occupational therapists currently practicing in the acute care setting discussed their feelings, beliefs and perceptions about the discharge planning process and what steps could be taken to

improve the process. The common thread throughout the data analysis and focus of most of the action plans was the importance of communication and increasing occupational therapy's visibility and contributions to the discharge planning process.

In terms of the first research question, participants shared views consistent with a community of practice. Their main concerns reflected a frustration with what they perceived to be a lack of respect or awareness of their contributions to the discharge planning process by those responsible for discharge planning. These were exemplified by their beliefs that discharge planners did not read their documentation and did not seek out their discharge recommendations, but rather relied on input from physical therapy. By not soliciting or considering occupational therapy's input, participants felt that patients could be put at risk of an adverse event. During the action plan phase, participants in Group 1 decided to distribute AOTA fact sheets on occupational therapy practice in the acute care setting, which participants felt increased awareness of occupational therapy services and in one instance, resulted in an increase in occupational therapy consults.

In addressing the second research question, participants cited many internal and external factors which guided their discharge decisions and recommendations. It appeared that the pragmatics of practicing within the acute care setting (e.g., time based issues, and hospital and health care system policies including payment sources) were key factors in therapists' discharge decision making. Group 1 participants decided to incorporate G-code compatible standardized assessments in an effort to improve the accuracy of their discharge recommendations, but participants did not find these assessments helpful for discharge planning.

In defining optimal discharge planning, participants believed ideal conditions were when all stakeholders including patients and families were in agreement on the discharge disposition, and patients received the necessary and recommended services. The underlying premise to optimal discharge planning appears to be an interdisciplinary approach of consensus, collaboration, and good communication including good rapport and relationships between stakeholders. Group 1 participants decided to change the language they used in documentation and incorporated the use of smart phrases, while Group 2 highlighted their discharge recommendations in their documentation. The use of smart phrases was deemed successful and reportedly maintained by some participants after the conclusion of the study. However, highlighting discharge recommendations could not be adequately evaluated as its use was inconsistent.

Lastly, the fourth research question was addressed through the action plans that were implemented. Of the four action plans, using the AOTA fact sheets to communicate to discharge planners occupational therapy's contribution to the discharge planning process and using smart phrases language in documentation appeared the most effective according to participant's responses.

Member Check and Peer Review

As described in Chapter 3, all participants—even those who had opted out of the study—were provided with the opportunity to review and provide feedback on the categories and themes that emerged from the data analysis. Two of the participants who dropped out did not respond to an email requesting feedback for member check, and one participant who remained for the duration of the study did not respond or provide

feedback despite two email requests. However, two participants who dropped out of the study did provide feedback.

On the whole, there was a general consensus among participants that categories and themes were an accurate reflection of the study data and acute care practice. However, Participant 1 stated she did not feel the word *constrained* was appropriate when the issue was occupational therapy consults that were too late to be of benefit to patients, and suggested changing the focus in language from constrained practice to holistic practice. In response, the word constrained was omitted. Participant 2 suggested that staffing discrepancies (more physical therapists than occupational therapists), may be responsible for increased awareness of physical therapy in the acute care setting over occupational therapy. Participant 9 felt that *borderline* was not the correct phrasing for discharges in which the patient discharge disposition was uncertain. She felt that borderline could be misinterpreted as patients with borderline personality. In response, the description of borderline patients was clarified. Participant 10 further validated the definition of successful discharge planning as when the patient, family, team, and insurer are on board so that patients get the services that best suits their needs.

In terms of peer review, two occupational therapy colleagues reviewed the categories and themes with supportive information and description of categories, and one occupational therapy colleague reviewed relevant data from chat transcripts (i.e., references to scheduling of subsequent chats or quality of audio sound were omitted). The peer reviewers discussed the material but also provided their own insight on the state of acute care occupational therapy practice. In reviewing their comments, the researcher had to separate out those comments where she felt the peer reviewers were judgmental of the

opinions expressed by the study participants, and instead focus on their review of the descriptions of the categories and themes that emerged.

Peer reviewers were in general agreement with the analysis, but one reviewer felt that pain and depression were not included as important elements in discharge planning as patients may refuse occupational therapy and then recommendations would need to be based on other information and not observation of the patient's actual engagement in functional activities. Another reviewer grew up abroad and felt that other countries with nationalized health systems take a more holistic view of patients than American occupational therapists. However, she did add that, in general, the profession of occupational therapy remains in many ways "misunderstood, and misinterpreted," as many patients are still unaware that the focus of occupational therapy is on restoring daily occupation in life. She also added that inpatient rehabilitation is a better environment for long-term patient discharge planning, as there is insufficient time in acute care to make these decisions because of medical issues, productivity expectations, and time conflicts. She was also in agreement with several of the study participants that there are many factors outside occupational therapy control including insurance companies dictating the discharge disposition.

Another reviewer felt that the responses of the study participants reflected confusion about their role, purpose, and value in discharge planning, externalizing identified problems and not taking a proactive stance. She felt this did not bode well for meaningful change to occur in practice patterns, communication, attitudes, or in making discharge recommendations. In addition, she felt that comments and strategies did not prioritize client-centered practice values. She also felt that the phrasing *lack of respect*

reflected a passivity and subservience in language in which participants did not expect things to change in themselves or their environment. Although the researcher did change lack of respect to *issues of respect*, she disagreed with the reviewer's comment as an aim of this study was to empower participants to reflect on their discharge planning practices and to take action through consensus to enact change.

Summary

This chapter analyzed data in response to the research questions, which explored (a) participants' description of their role in acute care discharge planning, (b) the factors that guide their decisions and recommendations, (c) their definition of optimal discharge planning, and (d) the actions they could take to optimize their discharge planning skills. This study provided a description of participants' experiences and views of occupational therapy's role in the discharge planning process including (a) current practices, (b) barriers to occupational therapy discharge recommendations, and (c) a description of several action plans and action research cycles. Participants identified several issues that they felt defined their community of practice as occupational therapists working in acute care, and discussed how to best raise occupational therapy's profile with discharge planners and other stakeholders, and to ensure that patients receive services that best meet their needs.

Chapter 5: Discussion

The present study used action research methodology to answer the research questions, (a) how acute care occupational therapists view their role in discharge planning process, (b) what guides acute care occupational therapists' discharge decisions and recommendations, (c) how do acute care occupational therapists define optimal discharge planning, and (d) what actions can acute care occupational therapists take to optimize the effectiveness of their discharge planning skills within the current health care system. Discharge planning has become increasingly important as hospital stays have shortened and patients are being discharged "quicker and sicker" (Jewell & Schultz, 2010, p. 1). Subsequently, patients are recovering and rehabilitating in settings other than the hospital, or are being discharged with unmet needs that can result in post-discharge adverse events. Comprehensive discharge planning is believed to be the most effective approach for ensuring smooth transitions hospital to home and reducing patient risk of readmission (Naylor et al., 2011).

As health care professionals, occupational therapists are obligated to ensure quality patient care including discharge planning, despite constraints often found within the acute care practice setting (e.g., short hospital stays and quick discharges limiting patient-therapist time). This is reflected in a paradigm shift for acute care occupational therapists that changed in focus from assessment-intervention-discharge to assessment-discharge (Craig et al., 2004). The therapist's knowledge, skills, and abilities are essential in discharge decision making given the complexity of the process in which client factors,

patient and family input, hospital rules, regulations, policies, and reimbursement sources need to be considered.

Summary of Earlier Chapters

Chapter 1 reviews issues related to challenges occupational therapists face in making discharge recommendations due to health care policies and trends, and the need to find strategies to improve discharge planning practices. Due to mandates of the Affordable Care Act ([ACA], U.S. Department of Health and Human Services, 2014) there is also an increased focus on reducing the risk of post discharge adverse events and reducing readmission rates. These are all areas in which occupational therapy discharge recommendations can have an impact.

The selected literature reviewed in Chapter 2 highlights the complexity of discharge planning including perceived barriers, constraints of the institutional environment and reimbursement sources, issues related to unmet needs post-discharge, and the knowledge, abilities, and critical reasoning skills of the therapist. However, it also highlights the importance of multidisciplinary collaboration, stakeholder communication, and the potential of discharge interventions to better prepare patients for discharge.

Chapter 3 details the action research methodology selected for this study and its rationale as a method that would empower the very people who are involved in occupational therapy discharge planning to enact changes in their own practice. Participant criteria, recruitment procedures, data collection methods, and issues related to the study's rigor were also described in detail. Two groups of participants met several times in an online audio chat format where they discussed current discharge planning

practices, perceived barriers, and solutions. Several strategies (i.e., action plans) were developed, implemented, and evaluated in addressing the research questions.

Chapter 4 discussed the findings of the study based on data analyzed using Stringer's (2014) action research data analysis methodology. The findings indicated that participants were predominantly interested in raising the profile of occupational therapists in the discharge planning process so that patients would have access to the services that therapists deemed necessary, or most beneficial in terms of safety and rehabilitation. Through consensus, several action plans were implemented with mixed feedback. Changing language and improving communication appeared the most promising strategies.

Discussion and Interpretation of Results in Context of Problem Statement, Literature Review, and other Theoretical Background

The participants in this study confirmed the problems raised in Chapter 1, particularly the numerous internal and external factors that challenge or pose barriers to occupational therapy discharge recommendations, many of which are outside occupational therapy control. These included (a) short hospital stays, (b) quick discharges, (c) limited time with patients, (d) issues relating to reimbursement, (e) ethical conflicts, and (f) constrained practice.

The participants in this study considered discharge planning a complex process but an essential part of routine acute care occupational therapy practice. They felt that hospital stays are so short that they frequently had to combine initial assessments with discharge recommendations, supporting the paradigm shift discussed in the sections Statement of the Problem and Selected Review of the Literature (Craig et al., 2004).

Participants felt that discharge recommendations were expected to be made with the very first patient contact, often with limited patient information or patient-therapist interaction time. One participant felt that the new Medicare penalties for frequent readmissions was a positive move as it would make hospitals more accountable for patient care and potentially counter the practice of quick hospital discharges.

The participants in this study also had the understanding that they had to work within a health care system that often posed barriers to their discharge recommendations, and a medical model system that was often at odds with what they perceived to be their holistic approach to patient care. Participants did feel they provided valuable input for discharge planning, but the ultimate decision did not rest with them but rather with physicians and case managers who often considered factors other than those considered by the participants in the study (i.e., mobility versus function). Additionally, despite their interest, participants acknowledged that currently there are no established guidelines and no one standardized assessment tool that is comprehensive enough to help occupational therapists predict the discharge needs of their patients within the diversity of the acute care practice setting.

Shortened hospital stays, cost containment, and prevention of readmission and adverse events seemed to be universal concerns related to discharge planning (Connelly et al., 2009; Mukotekwa & Carson, 2007). In addition to those issues, the literature highlighted many factors that posed challenges and barriers that oftentimes constrained occupational therapy discharge decision making. For example, there are time constraints, reimbursement and communication issues, ethical conflicts, client centeredness concerns, discharges with unmet patient needs, and a lack of comprehensive standardized

assessments to help predict and improve the accuracy of post discharge placement. This study validated and further explained several factors found in the current literature including the role of the acute care occupational therapy in discharge planning, the required knowledge, skills, abilities, and professional reasoning processes, and the factors that therapists consider when formulating their discharge recommendations. Other concerns raised by participants in this study that were similar to what was found in previous research include (a) time based issues, (b) issues of communication and respect, (c) use of standardized assessments, and (d) the pragmatics of working within the acute care setting.

The Role of Occupational Therapy in Discharge Planning

Acute care occupational therapists primarily see their role as focused on activities of daily living (ADLs) but also responsible for ensuring a safe discharge including making recommendations for equipment and follow-up services (Craig et al., 2004; Holm & Mu, 2012; Robertson & Finlay, 2007). Additional roles included helping to bridge the gap from hospital to home and assisting with the prevention of secondary complications. As previously mentioned, there has also been a paradigm shift in that the focus of acute care occupational therapy services has changed from assessment-intervention-discharge to assessment-discharge (Blaga & Robertson, 2008; Craig et al., 2004).

According to the findings of this study, participants saw themselves as taking the extra step of contacting necessary parties (i.e., case managers, social workers, physicians, and home health agencies) to ensure patients received the post-discharge care they needed. The participants in this study acknowledged there has been a shift primarily to assessment and discharge due to the nature of short hospital stays and quick discharges,

but they also saw themselves as providers of rehabilitation services. In addition, the participants saw themselves as educators, advocates, and team members that facilitated client-centered discharge planning. Phrases included gatekeeper, triage, and predictors of patient needs and safety risks. As in the literature, participants also considered themselves determiners of post-discharge levels of support and equipment needs.

Factors Considered in Discharge Planning

Factors related to discharge planning can be divided into two categories of internal and external factors. These two categories include factors that pertain specifically to the client (internal factors), and factors that relate to any conditions that are outside the client (external factors) but which may have an impact on the patient, his or her hospital stay and care, and discharge disposition. Both internal and external factors appear to be important considerations in acute care occupational therapy discharge planning and were similar in both the literature and in this study. For example, in both previous studies and data from this study, internal factors included patients' (a) cognition and level of safety awareness; (b) diagnosis; (c) physical functioning (past, present, and predicted future); (d) home situation, (e) level of family or caregiver support, (f) age, (g) pain, (h) co-morbidities, (i) level of motivation, (j) ability to participate, (k) importance of place and context, and (l) patient wants and needs. Examples of external factors included (a) issues of third party payers/reimbursement sources, and (b) health care and hospital rules, policies, and regulations.

Ambulation versus function. A key factor considered when determining discharge disposition appears to be level of mobility (Chang et al., 2014). Most of the literature (Jette et al., 2003; Kasinskas et al., 2009; Masley et al., 2011) that supported

mobility as the most important factor in formulating therapist discharge recommendations came from physical therapy studies, which is expected as ambulation is an important area within their scope of practice. The participants in this study also felt that greater emphasis is placed on ambulation than on function in discharge planning. According to Jette et al. (2003) and the participants in this study, occupational therapists tend to rely more on cognitive function and ADLs than on mobility in determining disposition.

The participants in this study expressed frustration that ambulation distance appeared to be used as a yardstick for setting the discharge disposition, with little attention paid to factors occupational therapists' consider when making discharge recommendations. They felt that occupational therapists tend to take a more holistic view of patient factors and context, similar to a study by Blaga and Robertson (2008) in which the occupational therapy subjects felt they had a more holistic focus than other disciplines. Participants also felt that occupational therapists delve a bit deeper to find out how patients managed at home prior to admission, and look for subtle cognitive issues that may have been missed by others. By not taking occupational therapy recommendations into consideration, participants felt patients could be at risk for an unsafe return home with unmet needs, increasing the risk of post-discharge adverse consequences. Participants also felt that patients and case managers need to appreciate that there is "more to life than walking" (Participant 1, G1, C1, L96) as patients also need to be able to manage their ADLs—a more involved process than ambulation. "It's easy to walk down the hall...than to manage things for ADLs" (Participant 13, G2, C1, L335).

Standardized Assessments

Mobility and function are central factors in discharge decision making; however, therapists have an interest in finding ways to increase the accuracy in predicting the appropriate disposition. As a means of improving this process, participants in previous research expressed interest in finding ways to use standardized assessments as tools to help guide discharge decision making (Jette et al., 2003; Robertson & Blaga, 2013). This interest is shared by the participants in this study as they recognized the potential benefits of using standardized assessments. However, despite the interest expressed in using standardized assessments by participants in this study and in the literature (Blaga & Robertson, 2008; Crennan & MacRae, 2010; Jette et al., 2003; Jette et al., 2014; Matmari et al., 2014; Robertson & Blaga, 2013), acute care therapists are not using them but rather relying on skilled observation of functional performance instead, except when there is suspicion of cognitive impairment.

Other researchers have suggested this may be due to standardized assessments being more time consuming than informal methods, or that therapists may be unfamiliar with standardized assessments that lend themselves to the acute care setting (Jette et al., 2014; Robertson & Blaga, 2013). This appeared to be supported by participants in this study who were unfamiliar with many standardized assessments. Participants also questioned their applicability to the acute care setting where they would have to be administered bedside to patients who were often critically ill, vulnerable, or not feeling or performing at their best. Even the few standardized assessments used by the participants were predominantly cognitive screenings, and often only parts of the assessment were used so that the assessments were not used in their standardized format.

The most common method of cognitive screening was done informally while talking with patients or observing them while engaging in a functional activity.

Participants stated when working with patients they were always on the alert for any *red flags*. This provides further support of the literature for assessment in acute care being based on observation of patients engaged in a functional task rather than reliance on standardized assessments (Blaga & Robertson, 2008; Crennan & MacRae, 2010; Jette et al., 2003; Jette et al., 2014; Matmari et al., 2014; Robertson & Blaga, 2013).

Despite the rare incorporation of standardized assessment in routine practice, participants wanted to further explore the benefits of their use, and elected to implement several as part of their action plans for this study. Participants felt that standardized assessments could be useful as outcome measurements and would help them better communicate with stakeholders the rationale supporting their discharge recommendations. The results on their utility was mixed but the general consensus was that although quick and easy to administer, the selected assessments did not help with discharge decision making or discharge planning. However, one of the standardized assessments implemented by the group was the Boston University's AM-PAC assessment. Although the participants in this study did not find this tool useful as it was not sensitive enough to provide useful information for discharge planning, a study by Jette et al. (2014) did find the AM-PAC helpful in predicting discharge dispositions.

In a research study from Canada (Boronowski et al., 2012) there appeared support for an occupational therapy screening tool to identify patients with complex needs who were poor rehabilitation candidates, but it was primarily used to support the need for an occupational therapy pre-discharge home visit. Similar to the participants in this study,

acute care therapists in the United States are typically not funded to perform pre-discharge home visits because home visits are relegated to those therapists providing home health services.

There is also no one standardized assessment tool currently available that is comprehensive enough for the acute care setting (Boronowski et al., 2012; Crennan & MacRae, 2010). Participants in this study are in agreement that they were unfamiliar with any standardized assessment currently available that addressed the diversity of patients found in acute care. They felt this would be difficult to develop because of the level of medical acuity of many hospital patients, the diversity of diagnoses seen, and the difficulty of finding assessments that encompass all aspects related to discharge, such as safety and equipment needs.

Discharged with Unmet Needs

Another important issue for therapists, is working within the current realities and conditions of the acute care practice setting with its quick discharges and short hospital stays. Emphasis on quick discharges has led to premature discharges that although freed up beds for the organization, could consequently be detrimental to patient care and possible contributors to readmissions (Matmari et al., 2014; Wong et al., 2011). This may be due to patients being discharged when medically stable, but leaving the hospital with many still unmet needs (Connolly et al., 2009).

Participants in this study did not frame the issue as patients being discharged with unmet needs, but indirectly touched on this issue by acknowledging that their patients may have difficulty receiving occupational therapy services after discharge. For example, patients are not eligible to receive needed home health occupational therapy services if

there are no documented physical therapy or speech therapy needs. At present, physical therapy and speech therapy are qualifying services that must be documented in order to initiate occupational therapy. In addition, there were stories related by participants of patients who were cleared for discharge by physical therapy but who still had occupational therapy needs, or family members insistent on a discharge that was counter to the occupational therapist's recommendation of post-discharge services. A new finding was the general agreement that an *end of the week mentality* to quickly discharge patients before the weekend often led to readmissions after the weekend as patients were discharged prematurely or with unmet needs.

Understanding and Respect by Team Members

A predominant finding of this study was the perceived lack of respect for the contributions of the occupational therapists as they felt that their documentation was not being read by those involved in discharge planning. In prior studies, concerns about documentation as a form of communication have focused on team members not having time to read others' notes (Craig et al., 2004), or due to problems of incomplete documentation, excessive paperwork, or duplication of information (Bauer et al., 2009; Mukotekwa & Carson, 2007). Despite the confidence participants expressed in their documentation skills, they felt that the practice of not reading OT documentation demonstrated a lack of respect for occupational therapy services by disregarding or undervaluing their contributions to the discharge process. Participants often expressed frustration as they believed that if team members were not reading occupational therapy notes, then they would be unaware of occupational therapy recommendations. This may be supported by a study of New Zealand acute care occupational therapists by Craig et al.

(2004) in which participants felt that patients were discharged with little to no occupational therapy input.

Prior studies reported that therapists felt misunderstood, disrespected, and undervalued when occupational therapy input was not sought and recommendations were not acknowledged (Craig et al., 2004; Robertson & Finlay, 2007). Conversely, occupational therapists also felt appreciated and supported when their input was acknowledged and they felt excited, gratified, and took pride in the service they provided to their patients. These sentiments appeared to validate the feelings expressed by the participants in this study of feeling frustrated and disrespected when their input was not sought out; yet, they also appeared confident, fulfilled, and took pride in the services they provided to their patients.

Wilding (2011) also found that occupational therapists felt disrespected and misunderstood, but felt it may be something brought on by the acute care therapists themselves through their passive conformist behavior. Group 1 certainly did not seem passive and many stories were relayed of how they took the initiative to advocate on behalf of patients to get recommended services. However, the second group of participants did appear more passive. They often expressed that there were many things outside their control, and therefore, could not change. Thus, there was some evidence to support findings in Wilding's (2011) study indicating a passive stance and a perception that the lack of appreciation for occupational therapy services had to do with their practice and their position within the medical model system, without questioning whether it was due to system or organizational conditions or culture.

A lack of respect was also reflected in participants' beliefs that physical therapy recommendations are given precedence over occupational therapy recommendations. The lateness of orders for occupational therapy consults and the disinterest in occupational therapy discharge recommendations were interpreted by participants as a disrespect for occupational therapy, in contrast to the respect shown to physical therapy. This perception was based on physical therapy usually being sought out and consulted before occupational therapy, and physical therapy recommendations given more weight than occupational therapy recommendations. For example, participants stated they often heard the refrain *patient can go home if it's okay with PT*. There was one previous study in which an occupational therapy participant similarly felt she was excluded from discharge planning, as the discharge planner relied on the physical therapy evaluation when setting the discharge disposition (Huby et al., 2007).

It is interesting to note that the feelings of disrespect as expressed by participants in this study may not be unique as there is research in the physical therapy literature in which physical therapists felt a lack of respect when their recommendations were not followed, or their services were misunderstood and underutilized (Masley et al., 2011; Matmari et al., 2014). Another area of concern found in both the literature (Brown et al., 2012; Craig et al., 2004) and an area of frustration for the participants of this study, is the remaining confusion about the profession of OT as often stakeholders (i.e., patients, families, and physicians) were unable to differentiate between occupational and physical therapy services, or did not have a clear understanding of what occupational therapy was.

Professional Reasoning

Although professional reasoning was not the central focus of this study, it is an important aspect of discharge decision making and reflected in many of the stories relayed by participants. Professional reasoning is tied to the level of therapist experience with more experienced therapists able to formulate more holistic and comprehensive discharge recommendations than novices (Holm & Mu, 2012) and better able to make quick decisions often required in the fast pace of the acute care setting (Robertson & Blaga, 2013). For example, experienced therapists are better equipped to anticipate post-discharge patient needs and are more confident in their discharge recommendations with less reliance on the opinion or input of other team members (Holm & Mu, 2012; Robertson & Blaga, 2013). In addition, acute care therapists filter a variety of information relevant to the patient's discharge through the therapist's lens of their experience including information about health care regulations, policies, and input from other team members (Jette et al., 2003).

In this study none of the participants recruited were novices, as participants' experience working in acute care ranged from 3 to 32 years, and they appeared to have many of the attributes discussed in the literature (i.e., flexibility of thought). The participants in this study appeared conscientious about obtaining as much information about their patients as they could. If they were unable to obtain information from the patient, they reached out to family members or facilities where patients were admitted from. Participants appeared confident about their discharge recommendations, even if their recommendations conflicted with those of other team members. In those situations, they would contact those responsible for discharge planning and to discuss the rationale

behind their recommendations. The participants' professional reasoning was also called into play with patients who were borderline in terms of meeting criteria for acceptance into the selected discharge disposition, or when there was uncertainty about patients' safety for returning home alone. This involved participants grappling with issues of what is considered an acceptable level of risk of a post-discharge adverse event.

Theoretical Perspective

The findings of this study fit well with some aspects of Schell's ecological model of professional reasoning (B. Schell, personal communication, October 3, 2014; Schell, 2014; Schell et al., 2008). Although not all parts of this model were reflected in participants' responses, this model was invaluable in framing the issues and various aspects related to occupational therapy discharge planning including examination of internal and external factors that influence occupational therapy discharge decision making. The model's case analysis table (Appendix K), provides a good representation of the myriad factors considered with professional reasoning that underlies discharge decision making.

Factors that therapists consider in discharge decision-making are shaped and influenced by three main categories. The first is the therapist's personal and professional self and lens, the second is the client's self and lens, and the third is the practice context. There is also a fourth category in this model, which is therapy actions. In terms of this study, therapy actions were the action plans and action research cycles generated during the course of this study. Professional reasoning that underlies therapists' actions in discharge decision making and recommendations are shaped by their personal and

professional viewpoints, and the transactions between therapists, clients, and the practice context (Schell, 2014).

In this study there were no data that emerged relating to therapist's personal lens or embodied characteristics. In addition, client self and lens were also not included, as the focus of the study was on the viewpoints of the occupational therapists themselves and not their patients' viewpoints. However, participants did discuss specific client factors including situations where patients' or family members' wishes were in conflict with the occupational therapists' discharge recommendations.

Professional lens. The parts of Schell's ecological model of professional reasoning that were most applicable to this study were the therapist professional lens and the practice context. In terms of the therapist professional lens, participants felt their knowledge of what works with clients and their years of experience helped guide their discharge decision making thereby ensuring an appropriate and effective discharge recommendation. For example, one of the participants felt that as an experienced therapist she could see beyond the patients' immediate needs, which helped her put things in perspective for her clients.

Although it was not specifically discussed during the course of this study it was apparent (from responses and stories related by the participants) that acute care occupational therapists need a certain level of knowledge, skill, and ability to effectively engage in discharge decision making and discharge planning. In the literature these were described as knowledge of acute and chronic conditions, and medical and surgical interventions on body systems (Gorman et al., 2010). In addition, therapists required knowledge of the different discharge disposition options and criteria for admission,

limitations imposed by Medicare and other third party payers, a broad knowledge of diagnoses, and knowledge of theories that support practice (Craig et al., 2004; Gorman et al., 2010; Kasinskas et al., 2009). Although not directly addressed as in the literature, participants in this study appeared very aware of the criteria for admission, or the conditions required for the different discharge dispositions which they viewed as a contributor or conversely as a barrier to their discharge recommendations.

Past studies highlighted how therapists need the ability to quickly integrate large amounts of information, employ high level professional reasoning, and have good communication skills (Gorman et al., 2010; Masley et al., 2011). Additionally, therapists need the ability to rapidly adjust to changes in patient presentation and flexibility of thought to reassess and modify recommendations based on new information or input from others. Although these studies concerned acute care PTs, the thought processes and skills of occupational therapy and physical therapy are closely aligned (Jette et al., 2003). For example, a study by Jette et al. (2003) of the discharge decision making of occupational and physical therapists working in acute care found that both professions may have approached patient concerns differently, but both considered the patient's level of functioning and disability, severity, duration and prognosis of the patient's condition, and the length of time and effort needed for improvement. Occupational therapy and physical therapy also took into consideration the patient's wants and needs, patient's level of motivation and ability to participate, ability to learn, and the patient's context, whether there was a support system in place to assist the patient after discharge. The researchers found that both professions formulated discharge recommendations by synthesizing all the above patient information along with therapists' experience and skills, current health

care regulations, insurance coverage, issues related to hospital length of stay, and criteria for the discharge setting.

In the present study, flexibility of thought was reflected by participants stating they took into considerations the recommendations of other disciplines and would modify their recommendations based on information that was new or previously unknown to them (i.e., information about the patient's financial resources or home situation). Participants' knowledge and understanding of external factors also helped guide their discharge decision making. For example, some external factors considered included the criteria or qualifications for acceptance to rehabilitation, insurance coverage and financial considerations, and bed availability at the proposed rehabilitation facility. This was similar to a study in the literature (Gorman et al., 2010) in which acute care physical therapists considered the same external factors in discharge planning.

Practice context. The practice context refers to the physical aspects and social rules and expectations that are unique to the setting where therapy or professional interactions takes place (Schell, 2014). The distinctive characteristics of a practice setting influences therapy options, available tools, and shapes the nature of the therapy process. In this study the practice context encompasses the pragmatics or realities of practicing within an acute care setting. The action of discharge decision making and the reasoning supporting recommendations appeared to be influenced not just by participants' professional lenses (i.e., professional knowledge, skills, experiences, and beliefs) discussed above, but also by the uniqueness of the practice context.

The hospital context is often viewed as a barrier to comprehensive discharge planning as it is setting power differentials where the physician is the ultimate determiner

of discharge disposition (Connolly et al., 2009; Moats, 2006), and where the locus of control does not lie with therapists or patients. The participants in this study also expressed views that they often felt powerless, but more often it was the case managers rather than physicians that had the final say in setting the discharge disposition. Several of the participants also expressed frustration as they often had to work within conditions that were outside of their control. For example, one participant stated she was frustrated when patients had to linger in the hospital *for weeks on end* until a bed at a rehabilitation facility was available, or until a facility was found that was willing to accept the patient.

The practice context in Schell's model (Schell, 2014) also includes (a) people, (b) organizational norms and policies, (c) time based factors, (d) the physical set-up, (e) caseload, (f) payment for services, and (g) discharge options. In this study, the predominant areas appeared to be time-related issues, payment for services, and discharge options; however, other categories are also discussed below.

People. This category in the model encompasses all the principal actors involved in discharge planning including the patient, families, caregivers, and all team members involved in the discharge process. Input from patients and families, client-centered practice, communication between all stakeholders including documentation, and the relationship among stakeholders can influence therapists' professional lenses, clinical decisions, and professional actions. Challenges with client-centered practice concern the *people* involved in the discharge planning process.

Client centeredness. Although client-centeredness is a core value of occupational therapy and patients' wishes should be central, they often are not in discharge planning because of the realities of the current health care system. This can be due to power

differentials, lack of information sharing, or even differences in perceptions of patient needs between the patient/family and staff (Bauer et al., 2009; Huby et al., 2007). In addition, families often feel excluded from the discharge planning process (Hager, 2010). For example, there are few studies that include families as part of discharge planning interventions; nonetheless, this is important as family members are frequently patients' caregivers (Bauer et al., 2009). Seeking the input of patients and families was also often viewed as a process that delayed and complicated discharges or interfered with productivity (Pethybridge, 2004). Despite this, much of the literature advocates for the inclusion of patients and families in goal setting and in the discharge planning process (Bauer et al., 2009; Crennan & MacRae, 2010; Duxbury et al., 2012; Luker & Grimmer-Somers, 2009; Pethybridge, 2004; Robertson & Blaga, 2013).

The participants in this study did not directly address the benefits of patient and family input, but rather how often family members made client-centered practice challenging. Several stories were related by participants of how family members were insistent on a certain discharge disposition that was not in the patient's best interests, was unrealistic, or was in conflict with the occupational therapy recommendation. The phenomenon of families' wants being in conflict with team members' recommendations is also not unique to occupational therapy as referenced in a physical therapy study by Matmari et al. (2014).

No new findings were elicited in relation to client centeredness and discharge planning or the research questions. Although, the lack of focus in this study on client centeredness and discharge planning may be related to findings of a previous study (Maitra & Erway, 2006), in which hospital occupational therapists had the most difficulty

being client centered. As discussed in Chapter 2, there is speculation that the role of patients (i.e., as passive recipients) in a hospital setting may be a contributing factor to the lack of patient involvement in discharge planning.

Communication among stakeholders. The category of people includes the stakeholders involved as well as their relationships with each other. Effective communication is an important aspect of building and sustaining professional relationships and creating a positive work environment (Craig et al., 2004). In addition, many studies suggest that good communication is associated with better patient outcomes (Craig et al., 2004; Crennan & MacRae, 2010; Hickman et al., 2007; Pethybridge, 2004), while poor communication between stakeholders is associated with poor discharge planning (NQF, 2009; Joint Commission, 2012).

The results of this study also underscored the value of good communication among all stakeholders as essential for successful discharge planning. For the participants in this study, that meant including action plans of educating physicians and case managers about the contributions of occupational therapy, and using more descriptive language in documentation. Wilding and Whiteford (2007, 2008) highlighted the importance of how occupational therapists communicate the unique contributions of occupational therapy in the acute care setting. This study expanded on those findings by suggesting the use of smart phrases and the practice of highlighting discharge recommendations and placing them at the top of occupational therapy documentation. Participants of this study also felt that the language and outcomes from standardized assessments could be an additional tool in improving communication with other stakeholders.

In both the literature and by participants in this study, multidisciplinary teamwork and collaboration were viewed as essential for effective discharge planning. However, participants in this study also considered developing relationships with discharge planners to be a key method of strengthening rapport and communication. Conversely, the common sentiment expressed by participants in this study was that they often felt misunderstood and disrespected by other team members.

Organizational norms and policies. This category includes teamwork and power relations. For example, participants' saw the case managers as being the primary person in control of discharge planning, with the physicians as secondary. Participants also unanimously felt that physical therapists were in a more powerful position than occupational therapists in terms of therapy consults and discharge recommendations. As previously mentioned this was often translated as a lack of respect for occupational therapy services. However, those participants who stated they routinely attended neurological or orthopedic team rounds felt they were generally respected by other team members, their voices were heard, and their recommendations taken into consideration. Those participants who worked on other floors or other services stated they did not routinely participate in formal patient care meetings, and did not feel as respected, or that physicians even knew who they were. Regardless, all the participants reported they had a good rapport with other allied health services in their departments (i.e., physical therapy and speech therapy) with each service supporting the other.

In terms of policy, one issue that was brought up was that occupational therapy cannot go in as a lone service for home health. Participants felt that this policy was unfair and did not serve patients well. For example, if a patient had a problem with low vision

or a cognitive impairment, but their mobility was good, then occupational therapy could not treat them in the home; thereby, disqualifying this discharge option.

Time based issues. Acute care is often considered a fast-paced practice environment, where time issues impact the provision of occupational therapy services (Craig et al., 2004). Time based factors in acute care are often multi-factorial as the time of day a patient is seen, the duration and frequency of occupational therapy visits, and the client's hospital length of stay have the potential to influence the quantity and quality of therapy services. The amount of therapy a patient receives before discharge can be an important factor in determining patient progress and the ultimate discharge disposition.

Time constraints were reflected in team members not having enough time to attend team meetings or read the documentation of others (Atwal & Caldwell, 2003a). Lack of time for team members to read documentation may validate participants' perceptions that occupational therapy documentation is not being read. Other time based issues included (a) having only a limited patient and therapist interaction time, (b) limited time to form comprehensive discharge recommendations with rapid decisions having to be made, (c) limited amount of time to prepare patients for discharge, and (d) insufficient time to ensure that support systems are put in place for patient discharge (Connolly et al., 2009; Jette et al., 2003; Masley et al., 2011; Matmari et al., 2014; Moats, 2006; Mukotekwa & Carson, 2007; Wong et al., 2011). Therefore, it is easy to see how time constraints can be seen in the literature as a contributor to poor discharge planning, premature discharges, and increasing the risk for readmission (Connolly et al., 2009; Matmari et al., 2014; Mukotekwa & Carson, 2007; Nosbusch et al., 2010; Wong et al., 2011).

The participants in this study also felt there was limited time to spend with patients in getting to know them, developing an occupational profile, or time to engage patients in therapeutic interventions. Results from this study highlighted participant frustration with the lack of timeliness of occupational therapy consults, which were routinely ordered *at the last minute*. Participants viewed this as a major barrier, preventing them from working with patients or getting to know them sufficiently to formulate an informed recommendation. The lateness of consults was also associated with issues of respect. For example, occupational therapy consults were often ordered after the discharge disposition had already been set, usually with input from physical therapy. Therefore, occupational therapy recommendations for discharge were superfluous or of little benefit to patients, unless necessary to support a transition to the selected discharge setting. In essence, occupational therapy consults were more of a formality than actual value placed on the occupational therapy discharge recommendation.

Previous studies highlighted the concern with quick discharges, which did not give patients the extra time needed to recover enough to ensure a safer discharge home. Some of the occupational therapists in this study also felt they were perceived as a service that would either delay or obstruct the established discharge plan. This is similar to previous studies where input from patients and families or a client centered approach to discharge planning was not sought out as it was viewed as a practice that delayed discharge (Pethybridge, 2004; Robertson & Finlay, 2007).

Participants also felt that another consequence of quick discharges is that discharge recommendations usually needed to be made at the time of the initial

occupational therapy visit. This was supported in the literature by the new focus on assessment-discharge replacing assessment-intervention-discharge in acute care occupational therapy practice (Craig et al., 2004). In addition, although this was not touched on in the literature participants also felt that following up on inappropriate occupational therapy consults were viewed as a waste of precious therapist time.

Physical set up. Participants only touched tangentially on physical set up, as patients are predominantly treated in their rooms. Hospitals are also an unnatural environment for patients, so it is difficult to simulate conditions to practice skills needed for a safe transition home. PredischARGE home visits was the focus of many occupational therapy discharge planning studies from Australia, New Zealand, and the United Kingdom; however, their utility was inconclusive and controversial (Robertson & Blaga, 2013). Although predischARGE home visits sound promising in providing information on a patient's home set up, current research in the United States is lacking as home visits are not part of routine discharge planning practices in the United States. One of the participants in this study was interested in doing a home visit for a patient, however was told she could no longer do home visits as it was against hospital policy. Most of the participants agreed that not having direct knowledge of a patient's home situation makes it more challenging in recommending equipment or services based on predicted home safety and post-discharge needs.

Equipment. Equipment traditionally refers to the tools such as adaptive equipment, assistive devices, or exercise equipment that are either recommended or used therapeutically to improve patient independence and function. However, assessment tools can also be thought of as the equipment that therapists use to help them in determining a

patient's level of function and needs for discharge. Refer to discussion of findings in Standardized Assessments section above.

Caseload. Issues with the number of patients on a caseload, fluctuating presentations, and medical acuity of patients were discussed. Participants commented that caseloads are large but occupational therapy departments are often short staffed, so many times participants were unable to spend the time with patients that they felt was needed. The makeup and diversity of therapist caseloads was also discussed by participants when discussing the challenges of creating an assessment that could cover the multitude of patient conditions seen in acute care. Although caseload size was not searched when reviewing the literature, the literature supported the need for acute care therapists to have a broad knowledge of different diagnoses as patient populations in the acute care setting are diverse (Gorman et al., 2010).

Payment for services and discharge options. Payment for services and discharge options are grouped together as in many ways participants felt that third party payers dictated their patients' discharge disposition options. Participants felt that insurance coverage determined where the patient would be discharged to, regardless of what was in the patient's best interests. This was often expressed as things outside occupational therapy's control and included issues relating to patients having to linger in the hospital because of no rehabilitation bed availability or no facilities willing to accept the patient. Participants also saw this as a conflict for patients who needed acute inpatient rehabilitation but could not be placed there because of financial considerations. Similarly, in the literature, reimbursement sources were often viewed as determinants of discharge disposition, which oftentimes conflicted with therapist recommendations; thereby,

constraining practice and becoming a barrier to client-centered practice (Jette et al., 2003; Kasinskas et al., 2009).

Issues of reimbursement and discharge options are often one of pragmatism for therapists where they have to be practical and realistic when making discharge recommendations for their clients. Other obstacles identified by participants included lack of insurance or other financial resources, lack of family or community support for the patient to return home safely, and the challenge of making a decision about disposition when information about the patient's prior level of function or availability of home support was unknown.

Optimal Discharge Planning

Understanding what optimal discharge planning means to acute care occupational therapists is key for setting goals and finding ways for therapists to improve their discharge planning skills. The literature describes optimal discharge planning as patients being discharged safely to the correct setting, with needed post discharge supports put in place that are not in conflict with hospital policies and processes (Matmari et al., 2014). Optimal discharge planning was also thought of as effective methods that resulted in improved discharge planning (Atwal & Caldwell, 2003a; Bauer et al., 2009; Crennan & MacRae, 2010; Hager, 2010; Pethybridge, 2004). For the participants in this study, optimal discharge planning was described as conditions where all stakeholders were in agreement with the discharge plan, and the patients received all the necessary services and supports they needed for optimal rehabilitation and independence. This seems to support the literature's focus on comprehensive discharge planning.

Methods that improve discharge planning. The focus in the literature has predominantly been on finding methods that support comprehensive discharge planning and coordinated transitions as they are believed to reduce risk of readmission and adverse events. Based on data from this study and supported by the literature, it appears that multidisciplinary teamwork (Atwal & Caldwell, 2003a; Pethybridge, 2004), good communication among stakeholders (Crennan & MacRae, 2010; Pethyridge, 2004), education, and the inclusion of standardized assessments (Jette et al., 2014) were seen as contributors to successful or optimal discharge planning.

Much of the strategies in the literature to improve the discharge planning process included discharge interventions (i.e., early intensive discharge rounds, or patient education programs), multidisciplinary documentation, as well as transition and patient preparedness programs (Brown et al., 2012; Crum, 2011; Grimmer et al., 2006; Hager, 2010; Mistiaen et al., 2007). The goals of patient preparedness programs are to ensure a smooth discharge hospital to home while minimizing the need for post discharge assistance and reducing the risk of adverse events. As discussed in Chapter 2, Grimmer et al.'s (2006) patient-centered checklist PREPARED is one such program.

The participants in this study did not take that direction in their action plans as their focus was on increasing the visibility of occupational therapy and their contributions to the discharge planning process including methods to improve their documentation. Similar to the literature (Blaga & Robertson, 2008; Crennan & MacRae, 2010; Jette et al., 2003; Jette et al., 2014; Robertson & Blaga, 2013; Matmari et al., 2014) participants also explored use of standardized assessments to assist with discharge decision making, but in contrast to the literature participants did not focus on patients or on discharge

interventions. Although the various strategies in the literature and the action plans of this study differed, they did have the shared goal of improving the discharge planning process and patient outcomes. This highlights the continued interest and need for finding approaches and solutions that optimize the discharge planning process.

Conclusions, Interpretation, and Speculation About Results

The aim of this study was to find ways to improve the discharge planning skills of acute care occupational therapists. The researcher had assumed this study would result in discharge planning guidelines or perhaps a tool to help increase the accuracy of discharge recommendations. Instead the findings from this study focused more on perceptions of acute care occupational therapists about the visibility of occupational therapy, respect for occupational therapy recommendations, and the language used to communicate with other stakeholders.

This study attempted to answer the research questions of (a) how occupational therapists see their role in the discharge planning process, (b) what guides their discharge decision making, (c) what their conceptualization of optimal discharge planning is, and (d) what actions the participants in this study as acute care occupational therapists could take to improve their discharge planning skills within the current health care system. In terms of what guides discharge decisions and recommendations, it appears that the participants in this study focused on the same factors as those found in the literature. This also validates the holistic approach that occupational therapists have in that they consider both internal patient related factors as well as external factors, context, and the environment. This approach is instrumental in helping occupational therapists predict the types of supports patients will need once discharged. As discharges are so quick and

hospital stays are so short the input of occupational therapy would appear to be invaluable in preventing readmissions and post-discharge adverse events.

In terms of how the participants saw their role in the discharge planning process, the participants in this study were in accord with studies in the literature that saw their primary role as one of assessment and discharge planning. The participants in this study also felt they were more concerned with patient function, cognition, and safety than other services. The participants appeared comfortable with their own knowledge, skills, and abilities but frustrated that their contributions to the discharge planning process were not as valued as they thought they should have been. The participants did not appear to have any uncertainty or self-doubt in terms of their practice skills, as one of the participants stated “we know what we are about.” The overriding issue appeared to be more of how to get others to understand the value of occupational therapy services.

This was reflected in their comments about physical therapy recommendations being given more weight than occupational therapy recommendations, or occupational therapy consults being ordered last minute as a formality for discharge. There were several stories related of how physical therapy cleared a patient for discharge, the case manager had set the discharge disposition, but the occupational therapist had deep reservations related to safety concerns. For example, a participant related a story of how physical therapy cleared a patient for discharge home alone; yet, when the occupational therapist went to work on toileting with the patient, the patient completely missed the toilet urinating on himself and on the floor but lacked awareness that he could slip on the spill. Another story was related of a patient that was cleared by physical therapy based on

ambulation distance; however, the occupational therapist noticed that the patient used the rolling walker improperly during functional tasks and was at risk for falls at home.

In another example of how an occupational therapist looks at the broader context in determining patient safety to discharge home, one of the participants related a story of a family member who insisted that her mother be discharged home with home health therapy even though it was counter to the participant's recommendation. The patient had been admitted multiple times for falls, had advanced dementia, and only had occasional supervision at the assisted living facility where she resided. As the patient's occupational therapist, the participant felt the patient was not safe to return home without 24/7 supervision and would require more than home health occupational therapy and physical therapy services to address her needs. The participant tried to educate the patient's daughter about her mother's condition and consulted with the social worker, but the family member was not in agreement. The participant felt morally obligated to document what she felt was the appropriate recommendation, but being pragmatic, also listed an alternate but less effective recommendation if the patient was to return home.

Regarding what occupational therapists consider optimal discharge planning, as stated earlier, the participants felt there should be agreement between all the stakeholders of what the discharge disposition should be, and patients should receive all the necessary supports they need in order to reach their full rehabilitation potential. More simply, the general consensus of participants was that everything was aligned when the patient got to go where they were supposed to, and the family and insurance were both on board. Although this is a worthy goal, the participants in this study recognized that the reality of the current health care system with its limited health care resources precludes the

possibility of all patients receiving all the recommended supports and services needed, unless there is a system-wide change in how health care and reimbursement for services are structured or delivered.

The action plans that the participants in this study adopted, although limited, did demonstrate how acute care occupational therapists can empower themselves to enact change within a system in which they at times felt undervalued or powerless to enact change. The majority of the action plans centered on improving communication and increasing occupational therapy's visibility in the discharge planning process. This validates findings in the literature that supports the importance of communication in acute care health systems, and would appear to build on the research of Wilding and Whiteford (2007, 2008) in which Australian acute care occupational therapists also felt undervalued and used changes in language to increase visibility and others understanding of occupational therapy's contributions to acute care patient care.

Another predominant issue for participants was their perception that physical therapy recommendations took precedence and were afforded greater weight than occupational therapy recommendations. This was interpreted by the participants as a general lack of respect for occupational therapy, and appeared in some ways to resemble sibling rivalry between two professions that are so closely aligned in the acute care setting. It may be a factor that physical therapy is a more concrete service with stakeholders more familiar with and understanding the importance of mobility. However, as one participant stated it may be more a factor of there being greater numbers of physical therapists working in acute care than occupational therapists, making physical therapy a more visible service.

According to the U.S. Department of Labor 2014 report (Bureau of Labor statistics, 2015a), there are approximately 200,670 physical therapists employed in the United States, with 11.6% working in acute care, per an American Physical Therapy Association (2011) work study. While according to the Bureau of Labor statistics there are 110,520 occupational therapists working in the United States (Bureau of Labor Statistics, 2015b), with 26.6% working in hospitals according to the AOTA (2010). Although it would appear by these figures that the numbers of occupational therapists working in hospitals is slightly higher than physical therapists, the perception remains that there are more physical therapists working in acute care than occupational therapists.

Therefore, although this may not bear out in reality, it appears that the participants in this study, colleagues the researcher has spoken with (K. Foley, personal communication, October, 2014), and from the researcher's own experiences working in fairly large occupational therapy departments, the number of staff physical therapists generally outnumbers staff occupational therapists. However, this does not explain why physical therapists have greater visibility and appear better represented, so that other stakeholders or team members seek them out for their discharge recommendations more so than occupational therapy. The participants in this study are correct though that there are approximately twice as many physical therapists employed in the United States than occupational therapists.

Another issue related to respect for study participants was the overriding sentiment that occupational therapy documentation is not read by those involved in discharge planning. However, the failure of other services to read occupational therapy documentation may not be a reflection of disrespect for occupational therapy. Perhaps

this may be another area related to time constraints where the reason that occupational therapy documentation is not read is because of insufficient time for team members to read occupational therapy notes, and not because they are ignorant, apathetic, or deem occupational therapy documentation unimportant.

Although it can be interpreted from the findings in this study and the literature that occupational therapy's power is limited within the medical model system, a percentage of participants reported that they made some sustainable changes that influenced their practice. For example, several participants stated in their exit surveys that they continued to use smart phrases and started making other changes in their communication and documentation practices. Findings in this study also provided support for previous studies that explored occupational therapy, physical therapy, and nursing attitudes towards acute care discharge planning in the United States and abroad. For example, communication, use of standardized assessments, multidisciplinary teamwork, and planning for post-discharge needs were all deemed important.

Although this study appears to support many of the findings of other discharge planning studies in the literature, there were some differences as the present study was narrower in scope and did not focus on all the factors related to discharge planning found in the literature. For example, client centeredness is identified as an important issue in the literature and is a core value of occupational therapy practice, but it was more of a side issue in this study as most of the discussion centered on therapist actions and feelings and not patient input. However, this might have been the nature of the format of this study as a forum in which participants could voice their personal and professional feelings and

opinions and where they chose not to reflect consciously or unconsciously on client centered care practices.

In terms of other differences, although participants also had issues with limited patient-therapist interaction time as found in the literature, their main time based issue was with late consults for occupational therapy. The literature also discussed the view of input from patient and families as delaying discharge, while the participants in this study felt that discharge planners viewed occupational therapists as the obstructionists by causing changes or delays in the discharge plan. In the literature, the discharge disposition is often set with little to no input from occupational therapy. In this study the participants felt strongly that their documentation was not being read, which they interpreted as a sign of disrespect, especially as physical therapy recommendations were perceived as having more weight than occupational therapy recommendations. In the literature, physicians were also seen as the ones responsible for determining patients' discharge disposition. However, in this study the participants felt it was largely case managers and not physicians who set the discharge disposition and who were the persons that occupational therapists needed to approach and convince about incorporating occupational therapy discharge recommendations.

The findings of this study may change the thinking about how discharge recommendations are formulated. Through review of the literature and the findings of this study, other acute care therapists may realize they have the same knowledge and experience as the participants in this study. Any uncertainty or challenges they have with formulating discharge recommendations may be a factor of not having all the facts or information at the time on which to base the most appropriate discharge recommendation.

occupational therapy discharge recommendations may also differ from physical therapy as both services may see the patient at different times of the day or on different days. In essence, a patient's presentation can be different depending on the time seen, which would affect the therapist's recommendations.

Additionally, more in depth patient related information and the development of a more defined occupational profile would facilitate more meaningful and client-centered discharge recommendations. This could include expanding therapist's toolboxes to include use of standardized assessments, participation in multidisciplinary team rounds, and greater communication with other team members.

Implications for Practice

The participants in this study felt strongly that their documentation was not being read. In response, as part of their action plans they elected to use more descriptive language (i.e., smart phrases) in their documentation and distributed AOTA fact sheets educating discharge planners on the scope of occupational therapy services in the acute care setting. These strategies appear to have the potential to effect sustained change in encouraging discharge planners to access occupational therapy documentation and discharge recommendations.

It is important for those responsible for discharge planning (i.e., case managers and physicians) to access therapy notes as it can have ramifications on patients' well-being. For example, in an occupational therapy study by Smith et al. (2010) they demonstrated that when therapists' recommendations were not followed, there was an almost 3 times increased risk of patient's being readmitted to the hospital. Although this is a physical therapy study, it underlies the importance of therapy recommendations in the

discharge planning process and its implications. The discharge setting itself can have ramifications on rehabilitation recovery, as in a study of stroke patients where those discharged to an acute inpatient rehabilitation had better outcomes than those discharged to other settings (Chan et al., 2013).

Another area of concern to occupational therapists in this study and in the literature was the reliance on patient mobility (i.e., ambulation) as a primary determinant of discharge destination or readiness for discharge. For the participants in this study, this was further support for their perception that physical therapy recommendations take precedence over occupational therapy input. However, this may not be a reflection of disrespect for occupational therapy's scope of practice and focus on function. Perhaps the interest and value placed on the ability to walk expressed by both physicians and patients is what generates more timely or routine physical therapy consults, as ambulation is considered a major area within the physical therapy scope of practice. However, it is time that occupational therapy tried more vigorously to change the public's and other health care providers' focus from mobility to function, as many study participants pointed out there is more to life than just walking as people also need to have the ability to care for themselves and engage in those occupations that make life meaningful. On the other hand, lower extremity function has been identified as a risk factor for mobility and ADLs disability in older adults (Stenholm, Guralnik, Bandinelli, & Ferrucci, 2014), and as occupational therapists pride themselves on being holistic they should not discount the importance of patient mobility and ambulation in their assessments for discharge.

Increasing therapists' awareness of older patients' passivity and lack of involvement in the discharge planning process (Huby et al., 2007; Huby et al., 2004;

Maitra & Erway, 2006), and finding ways to increase their participation may also have implications for practice. This will have increasing importance as the older adult population is the fastest growing segment of the population in the United States. In addition, therapists need to be more aware of power differentials and to not only rely on their own judgment but also on patient and family input. This could be accomplished through increased information sharing and making a more concerted effort to include patients in the discharge planning process. This may also increase patient satisfaction with their discharge, as according to a study by Mukotekwa and Carson (2007) patients were dissatisfied with their discharge plans when they felt excluded and uninformed.

The timing of occupational therapy consults, also has implications for practice as last minute consults prevent patients from having the opportunity to begin their rehabilitation journey by working with occupational therapy services. As a method to increase awareness of occupational therapy's contributions to discharge planning and the timeliness of occupational therapy consults, participants distributed to case managers and physicians the AOTA fact sheet *Occupational Therapy's Role in Acute Care*. Feedback on this action plan were mixed; however, one participant noted an upward trend in occupational therapy consults. This is also related to communication issues, and in both the literature and this study good communication was highly valued as a strategy necessary for coordinated and comprehensive discharge planning. Therapists should be encouraged to continue raising their profile and other stakeholders' understanding of the valuable services that occupational therapists provide, so that occupational therapy consults will be generated in a timelier manner. For example, occupational therapists

need to impress on stakeholders that their services have the potential to result in a patient being discharged home with less needs and therefore less caregiver burden.

The development of a network specifically developed for occupational therapists practicing in acute care may also improve practice. Several of the participants felt that having the support of other therapists working within the same conditions of trying to meet productivity and other administrative standards, while meeting patients' needs in a client-centered and evidence-based approach would be very helpful. These participants felt that having the support and access to other clinicians' resources, strategies, and suggestions was needed and perhaps has the potential to transform practice. Setting up a network or forum for occupational therapists who practice in the acute care setting could involve using other technologies, social media, or planning regular local or regional meetings or video chats. Perhaps a group could be built on the Canadian study by Egan et al. (2004) or the Australian study by Wilding et al. (2012) which connected therapists from across their respective countries. For example, at present there are occupational therapists that are developing tools related to discharge planning in acute care (M. Neville, personal communication, April 17, 2015). It might be helpful to set up a forum where research could be shared and ideas could be discussed. Another suggestion might be to have AOTA designate acute care as its own specialty group or special interest section, as the participants believe that their practice area is unique from other occupational therapy settings.

Implications for Further Research

As mentioned earlier, the physical therapy study by Smith et al. (2010) demonstrates discharge planning has implications for client risk of post-discharge adverse

events and readmissions. Therefore, the accuracy of therapy recommendations is important. It would be helpful to know the accuracy of occupational therapy recommendations similar to the accuracy of physical therapy recommendations as in Smith et al.'s (2010) study. In addition, with the new Medicare mandates of HCAHPS surveys (CMS, 2014a) for patient satisfaction, it would be important to know whether the occupational therapy recommended plan was beneficial, deemed successful, or if the disposition plan met the patient's long term needs based on feedback from patients' and families' viewpoints.

The participants in this study have implemented several action plans, and in the literature there have been several suggested recommendations and strategies proposed to improve the discharge planning process, but what remains lacking are clear discharge planning protocols and comprehensive discharge assessments. A Delphi study of expert acute care occupational therapists' discharge planning practices and recommendations could provide the information needed to help generate discharge planning guidelines or tools (assessment or screening tools) that are quick, easy, and inclusive enough for the acute care setting. In addition, action research appears to be an effective research method for engaging those involved in acute care occupational therapy discharge planning, and could be another invaluable research approach.

As the participants in this study as well as the participants in Craig et al.'s (2004) study felt occupational therapy was misunderstood, undervalued, and disrespected, it would be important to know if these perceptions are accurate and widespread, and if so, what measures acute care occupational therapists could take to counter this. For example, another avenue for research would be to explore why occupational therapy

documentation is not being read, what discharge planners or case managers actually do read, and why physical therapy recommendations appear to carry more weight than occupational therapy recommendations.

Other avenues for research might include exploring ways to change the perception that client-centered occupational therapy recommendations delay the discharge process, and why occupational therapy discharge recommendations are not being sought out by those responsible for discharge planning. As one participant stated, “why aren’t they paying attention?” If acute care occupational therapists had the answers to these questions, they would have the knowledge on which to make practice changes so that occupational therapy would be a sought after service as others would recognize the value of occupational therapy contributions to the discharge planning process.

Most therapists also have an understanding of how managed care affects practice; however, with a relatively new health care law more research needs to be conducted to examine how the new law is impacting occupational therapy acute care discharge practices, and ways that occupational therapists can further contribute to a smooth transition hospital to home or to another setting. Research could also be conducted on the best strategies to engage occupational therapists to become members of hospital transition teams, or by therapists who are currently members of transition teams on how their input affects patient outcomes in transitions of care.

Research into transitions in general, not just from the acute care setting, is also warranted. For example, it would be helpful to know how decisions are made about discharge recommendations from other settings (e.g., acute inpatient rehabilitation facilities, skilled nursing facilities, long term acute care, hospice), how best to approach

associated ethical dilemmas, or even when or how therapy services should best be terminated.

Research is also needed for strategies on how occupational therapists can best prepare and educate patients, caregivers, family members, or even community support persons and organizations in providing continued support that optimizes client independence and ability to engage in meaningful occupations. In addition, it would be helpful to have more research on the types of support needed to best prepare students, novice practitioners, or those therapists newly transitioning to the acute care practice setting.

Being that acute care therapists operate within a medical model setting, it may be important to examine the power relationships and power differentials and their impact on occupational therapy professional reasoning, and steps that can be taken to elevate occupational therapy status. As the majority of occupational therapists are women, it would be interesting to know if power issues in the medical model system are gender based.

More research on models or expansion of current models should be undertaken to strengthen practice and areas of further research. For example, it would be helpful to have more research studies that deepened our understanding of occupational therapy clinical decision making processes and the utility of Schell's ecological model of professional reasoning (Schell, 2014), not just in acute care but also in other practice settings. Clinical reasoning is an important part of clinical decision making, so it may be important to examine whether the clinical reasoning processes used by therapists in the acute care

setting are different than those approaches employed in other settings or by different disciplines or team members.

In addition, more research is needed that provides supportive evidence of the efficacy of occupational therapy services within the acute care setting, or practices therapists have engaged in that have proven to reduce the risk of post-discharge adverse events. Studies with this focus can help supply evidence of the benefits of acute care occupational therapy and lend credence to occupational therapy services even beyond the acute care setting.

Implications for Education

For effective practice, acute care occupational therapists require a breadth of knowledge, skills, and abilities as outlined earlier in this chapter and in Chapter 2. This includes sophisticated critical reasoning skills. Therefore, educational programs at the basic or advanced levels (i.e., master's, advanced master's, and doctoral) should continue to help students develop effective critical reasoning skills. Although it may be challenging, it would also be useful to better prepare students for acute care practice by offering more fieldwork experiences in this setting, or providing courses specifically focused on this practice area. For those students who are interested in practicing in acute care it may be helpful to have exposure to acute care therapists through guest lectures or encourage students to read newspaper articles, blogs, or journal articles that are relevant to this practice area, or to access AOTA's OT Connections acute care forum or other networking opportunities.

It would also be helpful if master's and clinical doctorate educational programs or continuing education courses helped students and practitioners better develop leadership

and assertiveness skills for working in a hierarchical medical model system as found in the acute care setting. According to Wilding (2011), occupational therapists who practice in this environment are often complacent and conformist, and do a poor job of showcasing occupational therapy's contributions. Therefore, practitioners bear some of the responsibility for their perceptions of occupational therapy being an invisible service. As a means of combating this complacency and improving occupational therapy visibility, educational approaches should prepare students to have the courage to support their convictions and reflexivity about practice as these can lead to increased confidence, assertiveness, autonomy, and professional recognition (Wilding, 2011). If educators could better prepare students to be more assertive and confident in their knowledge and abilities, that would better prepare them for being equal members of a multidisciplinary team, and educating patients and other providers.

Additionally, many occupational therapists seem to have difficulty articulating the value of occupational therapy services or why they are needed, and often feel misunderstood, unrecognized, and undervalued by clients and other stakeholders (Wilding & Whiteford, 2007). As such, courses that focus on improving communication skills of students and practitioners can help highlight occupational therapy's contributions to client recovery and rehabilitation, as well as increase confidence that the services provided by occupational therapy are of value. Students are the future practitioners and representatives of our profession, and as such need to be able to state clearly what occupational therapy is so that other health care providers and consumers understand exactly what services occupational therapy provides and why.

There is also a need for continuing education courses that focus on using theoretical frameworks to support best practices and help clarify the scope of occupational therapy services, especially for older therapists who may not be familiar with many occupational therapy theoretical models and theories. Familiarity with theoretical models that support occupational therapy practice may improve practitioner confidence in explaining what underlies their practice and clinical decisions. As Mattingly and Gillette (1991) concluded in their article “Anthropology, Occupational Therapy, and Action Research,” increased professional confidence is important for professions such as occupational therapy, where other disciplines may not understand or value our contributions. Continuing education courses with a focus on strategies for effective discharge planning, acute care best practices, and improving documentation skills are also warranted, and may help not just with professional standing but also with reimbursement issues—an important aspect in the provision of therapy services.

Limitations and Delimitations Based on Results and Interpretation

The major limitations for this study were the number of participants and make up, attrition, and technical issues with the program used for the audio chats. The original aim was to recruit 10 to 12 participants. Although originally 10 participants were recruited, only nine were included in the study as the 10th potential participant never returned the informed consent form. Unfortunately, there was attrition which began after the first audio chat and the study concluded with only five participants. After the study conclusion of the first group, a second group of participants was then recruited in order to bolster the number of participants to a total of 10 for the study. If there had not been attrition, and there had been full and consistent participation of all the participants until the conclusion

of the study, the study might have been stronger although the focus or direction of the study may also have changed or gone in a different direction.

As the sample size was small and this was a qualitative study, the findings from this study cannot be generalized to the larger population of occupational therapists practicing in acute care. In addition, although participants were from across the United States, the majority of the participants were from the state of Georgia. This came about because of difficulty with recruitment for the second group. The same methods were employed for recruitment of the second group as the first, but were not as successful as in the first group. For this reason, the first group may have been more heterogeneous than the second group. Despite participants from the second group all practicing within the same state, they were not all employed at the same hospital or even in the same city. In addition, three of the participants from the second group were originally from different states and two were originally from other countries.

Due to the poor response to recruitment for the second group, the researcher then sent out recruitment letters and emails to hospitals with occupational therapy departments in Georgia, but not in any of the other 49 states. Perhaps the number of participants would have been greater and better represented geographically, but there are probably thousands of hospitals in the United States that employ occupational therapists and it was not feasible to send each one a recruitment letter, so the decision was made not to send recruitment letters to hospitals in other states.

In addition to the research groups, another limitation was posed by the technology selected as the instrumentation for this study. Despite consideration of other programs GoToMeeting was selected because of the program's ability to record audio sessions

without the recordings being saved on its server. This was an important consideration for confidentiality in this study. In the GoToMeeting program, any recordings made were saved directly onto the subscriber's computer. In addition, participants had the option of accessing the audio chats through the computer or by phone, and participants were able to see the researcher's desktop screen if there was a document that the researcher wanted to share with them. In addition, GoToMeeting has a function where the researcher has the ability to turn desktop controls over to a participant if there was something he or she wanted to share with the group.

Unfortunately, GoToMeeting did not work out as expected as the audio reception for those who accessed the audio chats by computer was inconsistent. There was some background noise (even for those using headsets and not laptop mics), and spotty reception making it difficult for the researcher and participants to hear and understand each other at times. Those who accessed the chats by phone had much better reception. Multiple calls to GoToMeeting technical support were of limited but some assistance. The desktop controls feature was also awkward to use and after several attempts was no longer used.

Another unforeseen obstacle was that the online evaluation of selected action plan survey did not work as planned. Participants were asked prior to the scheduled online meetings to fill out a brief survey on how well they thought the implemented action plan worked. The purpose of this survey was to obtain more information on the adopted action plan, however this strategy was abandoned as only one participant filled it out despite several email reminders to participants. It can be speculated that the poor response was a function of time commitment.

Only using audio chats and not video may be another limitation for this study. Due to the disembodied nature of an audio chat the researcher and other participants missed observing the body cues of others, an important aspect of communication. Perhaps there may have been more buy-in to the study, and more lively discussion had there been video in addition to audio chats, or if the researcher had elected to assemble all the participants in one room as an on ground focus group. There would have been no anonymity in the study but it might have increased the interaction in the study, and provided an opportunity for the participants to get to know each other and perhaps network after the study concluded. One of the participants stated she wanted to continue to dialogue after the study concluded but no other participants appeared interested.

A delimitation of the study was that it was spread out over several weeks and months but limited to only five sessions. That decision was made as the researcher thought five was a reasonable number of sessions to go through several action research cycles, and would be a sufficient amount of time to collect enough data for the study. In addition, the researcher did not want the study to become too much of a time commitment for the participants. For the first group where there was more active and lively discussion, the study may have produced more action plans and perhaps taken yet a different direction if the study was prolonged. A longer study might have provided the opportunity for more strategies to be implemented and evaluated, more time to delve deeper into the attitudes and beliefs of participants about discharge planning practices, and more time to focus on strategies for long term sustainable change.

However, this would have been true for the second group as saturation appeared to have been reached by the fourth chat; no new information was being elicited or

revealed. In addition, for the second group there was more complacency and a lack of motivation to effect change in their home practice setting, which the researcher found disappointing as the person looking for answers to the research questions. The reason why the second group was so different than the first group in terms of enthusiasm and participation is unknown.

Another unappreciated consequence of using an action research approach was that the action plans went in a direction the researcher did not anticipate, as they were directed by the participants themselves. The researcher's hope was that this study would produce a discharge screening tool or best practice guidelines for discharge planning, or at least the beginnings of material to develop either. The researcher did not anticipate that almost all of the participants would identify late consults, lack of respect, and occupational therapy documentation not being read as their prime concerns; although, the researcher may have had similar feelings when practicing in acute care. Another unanticipated but manageable difficulty was scheduling audio chats that were convenient to all the participants, as participants lived in different time zones and had conflicting work schedules.

In terms of information on discharge dispositions, participants were asked in their initial survey where they most often recommended patients be discharged to, as there was an interest in seeing if one disposition was routinely selected over another. The most frequent discharge disposition recommended across both groups was to skilled nursing facilities, followed by home health services, and then acute inpatient rehabilitation. The reasons why skilled nursing facilities was selected more than any other setting was not specifically examined. However, during the course of this study the participants only indirectly spoke about where they had recommended patients should be discharged to as

part of the stories they related. The discharge setting only seemed to be an issue in the context of barriers to patients being discharged to the setting that therapists recommended. For example, insurance issues dictating where patients could be accepted. It would have been interesting and more informative if the researcher had delved a bit deeper into this aspect of the study.

Another delimitation may have been not reviewing studies prior to 2004 despite knowing older literature could provide valuable information on managed care and how that has affected current health care practices. The decision was made to limit the review of the literature to the past decade to keep the focus on more current studies, especially as there has been a major change in our health care system within the past 5 years with the adoption of the ACA (U.S. Department of Health and Human Services, 2014). The mandates of the ACA and its long-term impact on health care and occupational therapy provision of services will likely be a source of research for many years to come.

In addition to limiting the literature to the past decade, the researcher did not specifically include studies on discharge planning for the elderly despite there being a great deal of literature on this segment of the population. This decision was made as acute care occupational therapists have to work with a very large age range (about 18 to 100 years of age or greater) of patients, numerous diagnoses, undergoing diverse medical and surgical interventions. Thus, the decision was made to keep the focus of this study broad and not limit it to only one segment of the acute care patient population, or to only those participants who worked with a specific age group or diagnosis.

Recommendations

One of the primary findings of this study was participants' feelings that occupational therapy lacked visibility and their services were undervalued as often occupational therapy consults were last minute, their documentation was not being read, and physical therapy recommendations had more weight and took precedence over occupational therapy discharge recommendations. It appears that lack of visibility is a larger issue than occupational therapists feeling slighted as it can have implications for the discharge disposition where patients may not receive the services that they need. According to Wilding and Whiteford (2008), occupational therapy visibility is an important issue as "a profession that is relatively unknown may be poorly placed to ensure that it receives appropriate recognition and remuneration, given that the health service market place is increasingly competitive" (p. 180). Occupational therapy provides a valuable service in the acute care setting, but it may be an underutilized service if others are unaware of the contributions that occupational therapists provide or can provide to the discharge planning process.

The action plans implemented by the participants in this study may be a small start, but more and larger scale strategies need to be put in place to improve occupational therapy visibility. Campaigns that raise awareness and educate the public about occupational therapy services may inspire consumers to demand occupational therapy services and then third party payers, physicians, and case managers may respond by routinely seeking out occupational therapy services. This may involve better public relations campaigns in addition to the present lobbying by AOTA, or even grassroot occupational therapists movements at the local level.

Occupational therapists are also experts in holistically assessing patient discharge needs, which would make them ideal members of hospital transition teams. occupational therapy expertise could help ensure smoother transitions hospital to home by decreasing the risks of patients being discharged with unmet needs. This may involve greater occupational therapy involvement in collaboration between hospital and community or home health occupational therapy service providers or telehealth (i.e., using telecommunications to provide and monitor long distance patient care).

It is also recommended that a working group be put together of acute care occupational therapists who will continue to explore discharge planning practices, so that perhaps more ideas are generated that promote sustainable system-wide changes resulting in improved patient outcomes. This may involve greater dialogue and networking between acute care occupational therapists nationwide. The present study was a small study, but the findings showed there were certain beliefs and attitudes that were shared by all the participants in this study. Therefore, it stands to reason that there are central issues that may challenge all acute care occupational therapists.

Acute care occupational therapists need to empower themselves to find ways to help themselves, especially if they do not hold the power to change others, or are constrained within the current medical model system. For example, occupational therapists cannot change the short lengths of stay or trends for quick discharges as that is the reality of the current health care environment. However, they may be able to find strategies that optimize discharge planning within the parameters of the limited time they have with patients, perhaps by finding better ways to determine patient post-discharge needs. This is especially important if the new model for acute occupational therapy

practice is one of assessment-discharge. If this is occupational therapy's role, then acute occupational therapists need to be at the top of their game in terms of assessment and discharge, as it may be a single opportunity to effect a difference in their patients' lives.

Summary

In this chapter there is discussion of the findings of this study in relation to current knowledge of occupational therapy discharge planning practices and conclusions drawn including implications for practice and research. The aim of this study was to improve the discharge planning practices of acute care occupational therapists, ultimately resulting in increased therapist competence, confidence, and improved patient outcomes. Findings from this study supported several premises about discharge planning found in the literature. For example, discharge planning is a highly complex but essential aspect of acute patient care where effective discharge planning is associated with multidisciplinary collaboration and good communication between all stakeholders. However, there are barriers—some outside occupational therapy control—that challenge and constrain acute care occupational therapy discharge planning practices. Participants were also concerned about feeling disrespected when their documentation was not read, and their input on patient discharge was seemingly not valued or solicited.

Although there was no one resolution of the problem of how acute care occupational therapists can optimize their discharge planning practices, there were several strategies that were discussed, implemented, and that showed promise. Finding methods to raise awareness of the contributions of occupational therapy in the discharge planning process, can benefit patients in preventing them from being discharged with

unmet needs, decrease the risk of post-discharge adverse events and promote patient satisfaction and quality of life, hallmarks of successful discharge planning.

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Appendix A

Informed Consent Letter

Consent Form for Participation in the Research Study Entitled Occupational Therapy Discharge Planning and Recommendations in Acute Care: An Action Research Study

Funding Source: None.

IRB protocol No. 10301216Exp.

Principal investigator

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For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information

Nova Southeastern University
Center for Psychological Studies
3301 College Avenue
Fort Lauderdale, FL 33314

What is the study about?

You are invited to participate in a research study. The goal of this study is to examine current acute care occupational therapy practices in the discharge planning process, and to explore at least one action that acute care therapists can take to improve their participation and effectiveness in the discharge planning process.

Why are you asking me?

We are inviting you to participate because you are currently working as an acute care occupational therapist with > 3 years of acute care experience. There will be approximately 6-12 participants in this research study.

What will I be doing if I agree to be in the study?

You will fill out a short online demographic questionnaire and exit survey. The demographic questionnaire should take you no more than 15-20 minutes to complete and the exit survey ~ 30 minutes. You will also participate in a maximum of 5 online audio chats that will last no more than 60 minutes each. The audio chats will be conducted through Gotomeeting.com. You will be provided with information on how to access the

audio chats through Internet calling (VOIP) or by calling a toll based phone number. The purpose of the audio chats is to develop by consensus some action that you will implement as part of your practice. In between audio chats you will also be asked to fill out a short online survey rating the benefits of the selected action. This survey should take no more than 10 minutes to complete. It is anticipated that this study will require a commitment of approximately 6 ½ hours spread out over several weeks. Any participant can be terminated by the principal investigator without regard to his/her consent if he/she breaches the confidentiality of the group, is disrespectful or inappropriate to other group members, or fails to participate in any of the audio chats.

Is there any audio or video recording?

This research project will include recordings of the audio chats. The audio recordings will be available to be heard by the researcher, Helene Smith-Gabai, personnel from the IRB, and the dissertation chair, Dr. Ludwig. Helene Smith-Gabai will arrange for a transcription company to transcribe the audio recordings. All recordings and transcriptions will be kept securely in Helene Smith-Gabai's home office in a locked file box and on her password protected private home computer. All recordings will be kept for 36 months from the end of the study, and will be destroyed after that time by shredding copies of paper transcriptions and notes, and deleting all related online files. Because your voice will be potentially identifiable by anyone who hears the recordings, your confidentiality for things you say on the recordings cannot be guaranteed, although the researcher will try to limit access to the tape as described in this paragraph.

What are the dangers to me?

Risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day, and all reasonable efforts will be made to minimize these risks. However, potential dangers can include breach of confidentiality, loss of privacy, time commitment and financial issues, or emotional distress and negative responses elicited during the audio chats. Although all questionnaires will be anonymous and participants will use pseudonyms during the audio chats, being recorded means that confidentiality cannot be promised. If you have questions about the research, your research rights, or if you experience an injury because of the research please contact Helene Smith-Gabai at (404) 307-8758. You may also contact the IRB at the numbers indicated above with questions about your research rights.

Are there any benefits to me for taking part in this research study?

There are no benefits to you for participating.

Will I get paid for being in the study? Will it cost me anything?

There are no payments for participation in this study. The only cost that may be incurred is if you join the audio chats by dialing through your telephone, as a standard long distance charge may be applied by your telephone carrier. However there are no costs to you (it is free) if you join the audio chats online using your laptop or computer's microphone and speakers (VOIP-voice over Internet protocol). If your computer does not have a microphone and speakers, a headset will be provided to you for free by Helene Smith-Gabai for the duration of the study.

How will you keep my information private?

All electronic data related to this study will be stored on the Helene Smith-Gabai's password protected private home computer, and all paper documentation related to this study will be kept in a locked file box in her private home office. The online questionnaires and surveys will be anonymous and will not ask you for any information that could be linked to you. Gotomeeting.com (the website we will use for the chats) is a secure site. You can visit the Go To Meeting's privacy policy web page (http://www.gotomeeting.com/fec/secure_web_conferencing) or access their Security White Paper

(http://www.gotomeeting.com/fec/images/pdf/Citrix_Online_Web_Conferencing_Security.pdf) if you would like further information. However, the transcripts of the tapes will not have any information that could be linked to you. As mentioned, the tapes will be destroyed 36 months after the study ends. All information obtained in this study is strictly confidential unless disclosure is required by law. The IRB, regulatory agencies, or Dr. Ludwig may review research records. In addition, you will choose a pseudonym to be used during all phases of this study so that your identity will remain as unidentifiable as possible. However, your true identity will be known to Helene Smith-Gabai and Dr. Ludwig, but will be kept private.

What if I do not want to participate or I want to leave the study?

You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Other Considerations:

If the researchers learn anything which might change your mind about being involved, you will be told of this information.

Voluntary Consent by Participant:

By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled *Occupational Therapy Discharge Planning and Recommendations in Acute Care: An Action Research Study*

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

Appendix B

Recruitment Material

Helene Smith-Gabai
30 South Battery Place NE
Atlanta, GA 30342

December 2012

Director of Rehabilitation Services
Name of Hospital
Atlanta, GA

Dear _____,

I am a doctoral student in the occupational therapy program at Nova Southeastern University. I would like to invite your full or part time occupational therapy staff with 3+ years of acute care experience to participate in my research study. The focus of my study is on examining what actions or strategies acute care occupational therapists can take to improve the effectiveness of their discharge planning skills and recommendations within the current healthcare system.

Participants will be asked to fill out two short online questionnaires (a demographic questionnaire and exit survey), and to participate in a maximum of 5 online audio chats lasting approximately one hour each. In addition, before each audio chat participants will fill out a short online survey rating the benefits of a strategy selected by the group. This should take no more than 10 minutes to complete. It is anticipated that this study will require a commitment of approximately 6 ½ hours spread out over several weeks.

All information obtained through the study will be kept confidential and in a secure location. There is no financial compensation for participation in this study. Participants can withdraw at any time.

If you have any questions, or if any of your staff are interested in this opportunity or would like to know more about it, please have them contact me at hsgabai@gmail.com or 404-307-8758.

Thank you for your consideration,

Helene Smith-Gabai

Listerv invitation

I am a doctoral student in the occupational therapy program at Nova Southeastern University. If you are a full or part time acute care occupational therapist with 3+ years of acute care experience, I would like to invite you to participate in my research study. The focus of my study is on examining what actions or strategies acute care occupational therapists can take to improve the effectiveness of their discharge planning skills and recommendations within the current healthcare system.

If you are interested in participating, you will be asked to fill out two short online questionnaires (a demographic questionnaire and exit survey), and to participate in a maximum of 5 online audio chats lasting approximately one hour each. In addition, before each audio chat you will fill out a short online survey rating the benefits of the strategy selected by the group. This should take no more than 10 minutes to complete. It is anticipated that this study will require a commitment of approximately 6 ½ hours spread out over several weeks.

All information obtained through the study will be kept confidential and in a secure location. There is no financial compensation for participation in this study. Participants can withdraw at any time.

If you would like more information about this study, or are interested in being a participant, please contact me at hsgabai@gmail.com or 404-307-8758.

Thank you for your consideration. I look forward to hearing from you.

-Helene Smith-Gabai

Appendix C

General Guidelines

1. In the interests of protecting your identity, all participants will be asked to sign into Go To Meeting using a pseudonym of his/her choice. You will need to enter your correct e-mail address; however it will not be visible to any of the other participants, only to Helene Smith-Gabi the principal investigator. If you join the audio chat by dialing in by telephone, your name will not be listed or visible to anyone.
2. All information expressed during the audio chats and through the course of this study will be kept strictly confidential. No personal information about who you are or where you work will be asked or should be volunteered.
3. Any information obtained during the course of this study should remain within the group, and not be discussed with outsiders. Whatever is shared in the chat room stays in the chat room!
4. No personal identifiable information should be revealed about yourself or any of your patients or co-workers. If discussing a case study or narrative about a particular clinical situation or client, descriptions are acceptable; but do NOT reveal any identifiable information. Use an alias for clients (i.e., Ms. Smith or Mr. A) and/or names of institutions.
5. Each participant will have the opportunity to express his/her opinions and perspectives, and every attempt will be made to ensure that each person has an equal chance to speak.
6. All participants will be truthful, respectful and non-judgmental of each other, even if the opinions, values and attitudes expressed by others in the group differ from your own.
7. Any participant can be terminated by the principal investigator without regard to his/her consent if he/she breaches the confidentiality of the group, or is disrespectful or inappropriate to other group members.
8. Each person involved in this study has knowledge and expertise on making discharge recommendations in acute care, and as such any information that is shared during the course of this study is important and of value.
9. Participants are encouraged to contact the researcher by e-mail or phone, if they have any questions or concerns about the study, or issues raised during the course of this study.
10. Participants are expected to uphold these occupational therapy professional behaviors throughout all phases of the study:
 - a. Honesty – with themselves and others
 - b. Communication - all forms of communication should be truthful
 - c. Ensure the common good – be socially responsible

- d. Competence – seek out opportunities to increase professional competence
 - e. Confidential and protected information - all information should be kept confidential
11. Participants can withdraw from the study at any time without providing a reason (to the researcher or other members of the group).
12. All participants will be using pseudonyms during the course of this study.
However, if after the study is completed, group members decide they would like *on their own* to continue the dialogue or network with other members of the group - that option will be available if agreed upon by the group; and extended to only those participants who are interested.

Appendix D

Initial Questionnaire

1. What is your highest level of occupational therapy education?

- ☐ BA
- ☐ MA/MS (Entry level)
- ☐ MA/MS (Post entry)
- ☐ DrOT or OTD
- ☐ PhD
- ☐ Post doctoral
- ☐ Other

2. Approximately how many years have you been practicing?

In OT ?

As an OT in an acute care setting?

3. Are you currently working full time or part time?

- ☐ Full time (> 30 hours/week)
- ☐ Part time (30 hours/week or less)

4. Please pick the 5 most important factors you consider in making discharge recommendations, and rank them in order of importance (1 = most important)

	1	2	3	4	5
Patient's age					
Current diagnosis and medical/surgical treatment					
Patient's functional level prior to admission					
Patient's living situation (i.e., alone, with family/caregiver support...)					

	1	2	3	4	5
Cognitive status and level of safety awareness					
Balance					
Vision					
Current level of ambulation/functional mobility					
Current ADLs and IADL performance level					
Patient's (and family) wishes and preferences					
Insurance (what it covers, what it won't)					
Use of a safety or predischarge screening tool or checklist					
The opinions of other team members involved in the discharge planning process (i.e., other disciplines' notes)					
Other (please specify or comment					
5. Approximately what percentage (0%-100%) of your discharge recommendations are to the following settings or programs? Total number should equal 100%.					
Acute inpatient rehabilitation					
Subacute rehabilitation					
Long term acute care setting (LTAC)					

Hospice
Nursing home
Home health
Home (without follow up services)
Outpatient
Cardiac or pulmonary rehabilitation
Rehabilitation day program
Total

6. Are your discharge recommendations generally in agreement with your patient's final discharge disposition?

☐ Most of the time

☐ Occasionally

☐ Rarely

☐ Never

Other (please specify)

7. How would you describe the role occupational therapy plays in the acute care discharge planning process?

8. What is your definition of effective or optimal OT discharge planning practices in acute care?

9. What barriers do you see to client centered discharge planning in your practice setting?

10. What time zone do you live in? What do you anticipate will be the best times for you to meet online (i.e., day of the week, time of day...)?

Appendix E

Exit Survey

1. How would you describe effective or optimal acute care OT discharge planning?
2. What is your view of the role of OT in the discharge planning process?
3. Has participation in this study added to your knowledge, competency, and confidence in making discharge recommendations for your patients? Please explain.
4. Do you feel your views about discharge planning have changed through participation in this study?
5. Are you planning on making any changes in your current discharge planning practices based on participation in this study? If so what changes do you plan on making?
6. In what areas do you see a need for further research on acute care OT discharge planning practices?

Appendix F

Selected Strategy Evaluation

Please rate the effectiveness or success of the selected strategy (1 = Positive or Affirmative, 2 = Neutral or N/A, 3 = Negative or No)

	1	2	3
Ease of implementation of the selected strategy			
Time commitment involved			
Departmental and multidisciplinary team support of the selected strategy			
Availability/accessibility of needed tools or equipment			
Need for additional therapist training			
Therapist comfort and confidence in implementing selected strategy			
General patient response to selected strategy			
Overall therapist view of selected strategy			

Optional: If you feel this strategy was not successful, please suggest an alternate strategy that the group can try. If there is a different issue you would like to see the group address, please list it here as well, including any suggested strategies you would like to see adopted.

Appendix G

List of Study Action Plans

1. Distribution of AOTA fact sheets on acute care practice to at least 5 case managers or social workers responsible for discharge planning
2. Implementation of G-code compatible standardized assessments. Selected assessments included: Barthel Index, AM-PAC 6 Click ADL, and the Patient Specific Functional Scale (PSFS)
3. Smart phrases (a collaborative list of keywords and phrases) - using language in OT documentation that is more descriptive and more reflective of the benefits and focus of occupational therapy services
4. Changing OT documentation by highlighting, increasing font, changing color or placement of discharge recommendations within notes

Appendix H

Strategies Currently Used By Some Study Participants

- Seeking out doctors, social workers, case managers, and speaking to them about discharge recommendations
- Communicating with the nurse practitioner (NP), family, case managers about client status, instead of relying on others to read occupational therapy (OT) documentation
- Arranging to speak to case management and hospitalist groups, and using case stories that highlight OT's contributions (i.e., explaining what OT is how OT has been effective in discharge planning)
- Participation in team rounds – appears to be routine for participants in the larger hospitals, and for certain services (i.e., neurology, orthopedics)
- Spending a few minutes every month with new interns/residents as they have their rotations
- Collaboration and discussion amongst OT and physical therapy (PT) staff about which service best equipped to address patient needs, or discharge recommendations/needs
- Follow up clinic for patients after discharge, in which OT, PT, and speech therapy (ST) are involved
- Use of limited standardized assessments, usually cognitive or balance/falls assessments (i.e., MOCA, SLUMS, KELS, Allen, Tinetti) to help make appropriate discharge recommendations

- Obtaining information on prior level of function from family or prior setting (i.e., nursing home, assisted living facility)
- Sit down and talk with case management and encourage them to page you
- Use OT month as an opportunity to educate hospital staff about OT
- Early mobilization programs (i.e., ICU) has raised awareness of OT
- Communicating directly with others, especially the case managers or social workers/Probably the most important, maybe the most effective strategy
- Educate staff, seek out staff to speak to them about patients
- Discuss with PT when OT and PT recommendations are different, and try to come to a consensus. If consensus can't be reached then maintain OT recommendation
- Don't just document but also seek out relevant people (i.e., case managers or team) to communicate their discharge recommendations to
- PT & OT discuss patient and discharge needs with each other
- Excel spreadsheet with patient info that updated daily - usually put together by PT
- NP and social work are go to persons in terms of discharge recommendations, not physicians
- Try to find other strategies, even back door, to educate patient why you think your recommendation to the next level of care is in their best interest
- Little fairs during OT month outside high traffic areas like the cafeteria, with some booths for grip and pinch testing, show different equipment, present different fliers and handouts. Made a contest who had the stronger grip, and a raffle

- Group picture posted on hospital Intranet site during OT month
- Heavily document their recommendation with supportive information, especially if their discharge recommendations differ from others
- Several of the participants had reported that they routinely used several balance (i.e., Berg Balance scale, Tinetti, Timed Up and Go) and cognition (MOCA, SLUMS, Allen) assessments

Appendix I

Strategies Discussed But Not Implemented

1. Meet with case managers and highlight examples of Occupational therapists working with patients
2. Contact IT to reformat electronic OT documentation so that discharge recommendations are listed at the top, not at the end of notes
3. Make a short video on the contributions and benefits of OT in the acute care setting, which all new doctors would be mandated to watch
4. Have family or caregivers take a video or still pictures of the patient's house on their cell phone or tablet so that therapists could visually see the patient's home layout. This way therapists would be able to make more informed and appropriate discharge recommendations about equipment needs and home safety.
5. Development of a standardized assessment whose outcomes would lend credibility to discharge recommendations
6. Development of a collaborative document or evaluation form so a lot of the same questions won't have to be asked of the patient from multiple disciplines

Appendix J

Smart Phrases Compilation

Assessment:

- Include detailed information on prior level of function (PLOF)
- Phrasing suggestions
 - Patient demonstrated no significant deviations to age appropriate thinking, attention, memory skills, or problem solving
 - Patient anticipated adequate vision and hearing for functional tasks
 - No concerns anticipated with areas not tested
 - Pain –
 - No action needed per patient
 - Addressed during session
 - Altered activity or time
 - Activities, handling, and positioning, modified within patient's tolerance
 - Consulted with nursing
- Patient unable to use xyz utensil (i.e., comb) appropriately

Questions to ask:

- How do you get your groceries? (question can provide more detailed information on patient's resources and PLOF)
- What are you looking forward to doing when you get home, or what kinds of things do you enjoy doing?
- What medications do you take? Is anyone helping you set up your medications? Do you use a pill sorter?
 - Want to make sure patients don't miss a dosage or take double medications (may need a memory aid)
- What would you do in an emergency?
 - What would you do if your caregiver needed to go to the hospital?
 - What would you do if your daughter fell in the house while visiting and needed to go to the hospital?

Phrases that can be used with EPIC:

EPIC Code	Phrase
.AGREE	Patient is agreeable to work with OT.
.AOXIII	Alert and oriented times 3 to person place and time.
.OXTRA	Orientation x 3 but requires extra time and scans room for cues to answers.
.OSIT	Oriented to situation and able to express needs and wants.
.IFASK	Patient able to express simple needs and wants if asked.

.DSIT	Disoriented to situation and unable to express needs and wants.												
.SLUMS	Patient participated in the Saint Louis University Mental Status Test (SLUMS) for Dementia using Veterans Administration score sheet.												
.DTEST	Scored in dementia range on SLUMS test.												
.MFVPT	Vision assessed with Motor Free Visual Perception Test.												
.LBAK	Patient lethargic but awake.												
.VAUGE	Patient is a vague and convoluted historian.												
.NEWINFO	Additional information obtained on patients prior to admission status.												
.NOPLOF	Patient does not consent for OT to contact family or prior therapist for prior level of function information.												
.TASK	Patient requires cues to focus attention and complete task.												
.IADLCOMP	Patient demonstrates cognition, health status and functional skills to resume age appropriate Instrumental ADLs including:												
.DISTR	Patient easily distractible and unable to complete task.												
.DYNO	Grip strength measurements with dynamometer R # L #												
.GONI	Right and Left upper extremity ROM measurements taken with goniometer as follows:												
.CIRC	<p>Circumferential edema measurements in centimeters</p> <table> <tr> <td>Right Upper Extremity</td><td>Left Upper Extremity</td></tr> <tr> <td></td><td></td></tr> <tr> <td></td><td>Base of index</td></tr> <tr> <td></td><td>Hand</td></tr> <tr> <td></td><td>Wrist</td></tr> <tr> <td></td><td>2" below Elbow crease</td></tr> </table>	Right Upper Extremity	Left Upper Extremity				Base of index		Hand		Wrist		2" below Elbow crease
Right Upper Extremity	Left Upper Extremity												
	Base of index												
	Hand												
	Wrist												
	2" below Elbow crease												
.DENIES	Patient denies numbness or tingling in arms/hands.												
DM NEUROPATHY	Patient with numbness and tingling due to diabetic neuropathy in fingers effecting dexterity and in feet affecting balance.												
.DECON	Bilateral arm strength WFL. However patient is at high risk for quick deconditioning due to age, diagnosis, extended bedrest and prior sedentary lifestyle.												
.CAPA	Patient capable to use call light controls and telephone.												
.DESKIN	Patient at risk for decreased skin integrity due to impaired mobility and poor po intake.												
.QUABL	Highly questionable safety for reaction to emergency situations.												
.NINEII	Unable to recall #911 emergency number.												
.MEDS	Patient reports taking medications directly from bottles and should have oversight with medications.												
.NAILS	Patient has long, thick, discolored toenails. Could benefit from Podiatry consult due to discomfort wearing shoes, decreased balance and increased risk of skin breakdown.												
.PTID	Patient able to identify												

.READ	Patient able to read wall clock. Patient able to read large print menu. Patient able to read name and phone number on professional business card.
-------	---

Look for these with L hemisphere event	Look for these with R hemisphere event
Anxiety	Impulsivity/
Slow performance	Rapid movement/performance
Difficulty understanding oral directions	Difficulty understanding demonstrative directions
Understands demonstration/pantomime	Understands oral or written instruction
Problems with speech (uttering sound)	Disturbed body image
Problems with language in general	Topographical disorientation
Unfamiliar situations result in confusion/disorganization	Disturbed position in space (no longer has spatial concepts ie: up, behind, over)
Needs much positive feedback	Disturbed depth perception
	Dressing, constructional apraxia
	Possible prosopagnosia

Interventions:

- Using the Allen Cognitive Levels (ACL) - Within Level 3, patient scored at Mode 3.2. At Mode 3.2 the patient requires 60% Cognitive Assistance: Person needs 24 hour nursing care to place objects in front of the person, and assist with toileting, bathing, grooming, and dressing. 1:1 supervision requires 60% moderate cognitive assistance to sustain actions. Individual preferences in what the person likes to move may be honored. 10% Physical Assistance for fine motor actions on all objects used in ADLs. Physical barriers or alarms to prevent getting lost and attempting to walk on anything other than flat surfaces without an escort. Put bed rails down to prevent attempts to climb over the top.
 - Abilities: Notices familiar objects that can be moved (paint and brush, sandpaper, tiles, faucet, magazines, picture books, shampoo, etc. Caregiver must make sure objects have no sharp edges and cannot be swallowed. Moves objects back and forth but may not look at effects on actions. Distinguishes between objects by size, color, or shape. Actions not sustained for longer than a few seconds. Speaks in short phrases. Remembers past use of common objects.
- Patient practiced reaching in various heights with __assist for balance
- Patient engaged in oral hygiene sitting edge of bed (EOB) with __assist for balance and task
- Patient practiced bilateral upper extremity (BUE) tasks at EOB, to increase balance for ADLs
- Patient educated on techniques to improve posture while sitting, and to facilitate upright spine/posture

- UE strength and tolerance increased to encourage patient use of UEs for BADLs (i.e., self feeding, oral hygiene, bathing)
- Patient practiced relaxation breathing as transitional activity, as patient with anxiety
- Patient oriented to the rehab process and the role of OT
- Patient engaged in UE exercise to increase strength and endurance needed for sustained activity and ADL performance
- Use clock test to assess cognition

EPIC Code	Phrase
.EDPLB	After instruction and practice patient was able to demonstrate pursed lip breathing with appropriate technique 10x.
.ISMB	Patient instructed to count aloud during “hard part” of exercise repetitions to facilitate air exchange and to self monitor respiratory endurance.
.EDPB	Patient educated to note how voice becomes strained at point of fatigue and normal after brief rest and recovery pursed lip breathing.
.FEETX	Patient educated on daily self care practices for diabetic feet. Handout issued and reviewed.
.LEAD	Lower extremity adaptive devices for self care.
.ISSUED	Patient issued and instructed with (putty, theraband, built up utensil, reachers, etc.)
.CATA	Patient issued consumer reference catalogue for examples of suggested items. Comparison shopping On Line recommended.

Clinical implications/recommendations:

- Give detailed information
- Laboratory value precautions
 - Hematocrit (Hct) <25%: too low for therapy; not going to be able to get to/from bathroom without light headedness
 - Hemoglobin (Hgh) <8 g/dL: too low for therapy. 8-10 fatigue/low tolerance (tachycardia common). No energy to prepare meals, feed dog, change cat littler, etc.
 - Platelets <5,000= bedrest. 5,000-20,000= seated ADLs and short ambulation. Monitor patient closely. Patient needs to have someone at their side all the time.
 - Glucose <60 or >300 - therapy is deferred. At the low end there is no recognition of what needs to be done and no energy to do it. Whereas with a high blood glucose level the patient can be delirious.
 - Prealbumin < 5.0 mg/dL indicates a poor prognosis. 5.0-10.9= patient at significant risk and needs aggressive nutrition first. Plan should be focused around eating

- Albumin levels increase with dehydration, but decreases with infection, shock or malnourishment. Norm $\geq 3-4$ mg/dL, either way there is potential for delirium
- Prothrombin time (norm 11-14 seconds), higher than 2x norm risks spontaneous bleeding. An INR >3 =risk of spontaneous bleeding. This example this includes activities like shaving one's legs, gardening, or chopping vegetables.
- The patient exhibited x, y, or z, therefore needs 1,2, or 3
- Patient scored a ____ on the Barthel Index. It is anticipated given his/her history of stroke that this problem will persevere, and so it is recommended that he/she discharge to an acute care rehab center. Occupational Therapy will provide care to address upper extremity function as related to daily occupations and to improve activity tolerance for the requisite 3 hours of therapy per day.
- Patient presents with new onset of cognitive impairments as indicated by his/her performance on the MoCA. If this problem persists it is anticipated that he/she will need continued rehab at a skilled nursing facility level of care to provide family training and teach environmental adaptations for a safe transition to home.
- Given the context the patient lives in and the demands of their environment I would recommend ____
- Patient is unable to evacuate home if an emergency arises
- Patient is at high risk of injury to self
 - Patient is unable to recognize potential environmental safety hazards
 - Due to instability, poor balance, or improper or inadequate use of assistive or DME equipment
 - Patient will not be able to escape house if an emergency arises
 - Patient has a high risk of falling (i.e., during the night)
 - Patient with insufficient visual scanning to enable/support safe mobility in community settings without an escort
 - Patient unable to hold information in short term memory while dealing with an unrelated situation (implication: questionable ability to return to item cooking on stove surface if interrupted by doorbell, telephone, etc). Therefore patient with high potential for risk to/loss of safety
 - Patient is unable to recognize common objects
 - Patient is not able to use common personal care/household objects as intended
 - Patient is unable to recall position of (or locate) an object that is outside immediate visual field
 - Patient is unable to anticipate or predict events despite being able to articulate the presence of the event in the past (i.e., estimate when the utility bill will arrive, estimate cost of groceries, etc.)
 - Patient does not see (recognize) soil on clothing, utensils or dishes
 - Patient does not recognize that failure to bathe for ____ days will result in body odor
 - Lacks awareness of hygiene which can contribute to skin breakdown
 - Patient does not recognize his/her impact on others or on environment (i.e., does not recognize that body odor/appearance is off putting to others. Does not recognize that uncovered garbage attracts scavengers which can impact

safety. Leaves food/clothing/objects when done with them for others to take care of)

- Finger deformities prevent safe operation of microwave
- Hand/finger weakness prevents safe lifting of containers when using appliances (i.e., stove or microwave)
- Visual acuity is such that the patient cannot see markings on stove top controls to cook meals
- Patient is unable to open packages/containers of food due ____
- Patient with difficulty with divided attention (give example of what this means)

EPIC Code	Phrase
.OOBEND	Patient will tolerate 1-2 hours out of bed in chair for light activity, ADL, and patient education.
.OTCOG (goal)	Patient will demonstrate attention to task for a minimum of 8 minutes to participate in self care task.
.OTPGR (goal)	Patient will demonstrate phone skills to read a phone number, dial sequentially in timely manner, and follow the phone prompts to activate therapist's pager.
.FEETGOAL (goal)	Patient with diabetes will have increased knowledge safe and healthy daily ADL practices for their feet.
.TEACH (goal)	After teaching and issue of reference materials patient will identify 3 or more choices and intentions on ways to improve safety with Basic and Instrumental ADLs.
.OTENDURANCE	Patient will tolerate 15-30 minutes self care and or upper body exercise with stable vitals.
.OTGROOM (goal)	Patient will perform grooming from edge of bed or chair with
.EDLEAD (goal)	Patient will be modified independent for dressing, bathing and toileting utilizing adaptive devices to accomplish within post-op restrictions.
.HIP	Patient able to state all hip precautions and apply to ADL. Patient has been issued precautions handout.
.SPINE	Patient will be able to state all post operative spinal precautions and apply to ADL.
.LEADBK	Patient will perform lower body self care with reduced exertion and strain/pain.
.GOALTUB	Patient will transfer in and out of tub with verbal and tactile cues for appropriate use of tub bench.
.EXPROG (goal)	Patient will participate in progressive upper body exercise to achieve a ½ grade and 3-5# increase in strength by discharge.
.OTEDEMAGRIP	Patient will demonstrate decreased upper extremity edema to allow for functional grasp during activity.
.OTEDEMA (goal)	Patient will demonstrate knowledge of edema control techniques for elevation and AROM exercises.
.REACH (goal)	Patient will use reachers to safely retrieve light weight items to compensate for decreased dynamic balance.

.OTRESORC (goal)	Patient will have increase knowledge community resources and reference information for (Arthritis Foundation programs and services, Low Vision Clinic and Optometry Services, Dental Clinic, Wheelchair seating Clinic, Driving Rehabilitation, Cancer Support Programs for patients and families.
.OTDCREC (goal)	Patient, family and staff will have final discharge recommendations regarding equipment and post discharge therapy depending on progress.
.SUPV	Upon discharge patient requires 24 hour supervision and assistance with Basic ADLs and or Instrumental ADLs.
.HOME	Patient is safe to return to their prior environment from a self care aspect with
.STATUS A	Patients status per OT goals: (cut and paste goals from last note)
.GMET	Goal met (dates)
.GINIT	Goal Initiated
.GPROG	Goal Progressing
.GANOT	Goal addressed but not met
.GPM	Goal Partially Met
.GODC	GOAL Discontinued
.NEWG	New Goal # ()

Documentation Tips:

- Use a thesaurus for more descriptive words.
- Document the quality of the task performed (poor, fair, good)
- Document the reasons patient unsafe to return home alone: unable to anticipate/recognize safety issues and unable to respond appropriately due to impaired safety awareness, deficit awareness, etc...
- Provide problem solving safety scenarios: Patient unable to problem solve safety solution for home fire scenario (verbal). When asked what he would do if there was a fire his response was "Nothing...I can't do anything." When guided/cued to think of who he would call patient responded with '911' but unable to problem solve how to get the phone quick enough (in other room charging).

Notation from Participant 8: our value to the patient and treatment team is interpreting data (i.e., scores from standardized assessments) into 'what it means in real life', and in developing a plan to reduce or prevent the negative impact.

Appendix K

Schell's Ecological Model of Clinical and Professional Reasoning

Case Analysis

Therapist	Notes from my case
<ul style="list-style-type: none"> • Personal Self 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Personal characteristics including intelligences, personality, bodily experiences and preferences 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Personal gestalt, including life experiences, world view, values and beliefs 	
<ul style="list-style-type: none"> • Personal lens – the worldview through which the individual who is a therapist considers and filters information 	
<ul style="list-style-type: none"> • Professional self 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Professional knowledge 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Practice theories and beliefs 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Practice skills and experiences 	
<ul style="list-style-type: none"> • Professional lens – the professional view through which the therapist considers and filters information re: the therapy process and outcomes. 	
Client	
<ul style="list-style-type: none"> • Personal Self 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Personal characteristics including intelligences, personality, bodily experiences and preferences 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Personal gestalt, including life experiences, world view, values and beliefs 	
<ul style="list-style-type: none"> • Personal lens – the worldview through which the individual who is a the client considers and filters information 	
<ul style="list-style-type: none"> • Client self 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Health or occupational concern 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Health & occupational knowledge 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Health & occupational theories and beliefs 	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Therapy skills and experience 	

<ul style="list-style-type: none"> • Client lens – the client view through which the client considers and filters information re: the therapy process and outcomes. 	
Practice Context – The physical, social historical and political situations in which the therapy process is imbedded.	
<ul style="list-style-type: none"> • People <ul style="list-style-type: none"> ○ Team members, supervisors, etc ○ Families, caregivers associated with client 	
<ul style="list-style-type: none"> • Organizational norms and policies <ul style="list-style-type: none"> ○ Teamwork ○ Expectations ○ Power relations ○ Priorities 	
<ul style="list-style-type: none"> • Time-base factors <ul style="list-style-type: none"> ○ Schedule ○ Treatment duration (per session and overall) ○ Frequency of visits ○ Distribution of time among players 	
<ul style="list-style-type: none"> • Physical set-up <ul style="list-style-type: none"> ○ Space (volume and quality..ie, access to natural contexts vs contrived settings) ○ Supplies and equipment ○ Variety 	
<ul style="list-style-type: none"> • Caseload <ul style="list-style-type: none"> ○ Number of clients ○ Kinds of clients ○ Prioritization process 	
<ul style="list-style-type: none"> • Payment for services <ul style="list-style-type: none"> ○ Insurance or coverage ○ Private pay 	
<ul style="list-style-type: none"> • Discharge options 	
Therapy actions – What actually occurs in all phases of evaluation, intervention, discontinuation and follow-up	
<ul style="list-style-type: none"> • Intervention focus 	
<ul style="list-style-type: none"> • Intervention approach <ul style="list-style-type: none"> ○ Actions (occupational, purposeful, preparatory, passive, discussion based) 	

○ Verbalizations (regarding therapy approach, health conditions, administrative issues)	
• Individual vs. shared interventions (ie, team treatment, family-based)	
Therapy measures – Explicit statements of desired and actual outcomes which are a result of the therapist-client transaction in the practice context.	
• Goals	
• Outcomes	